

2011

MO HealthNet Managed
Care Program

External Quality Review

Report of Findings

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I.0 EXECUTIVE SUMMARY

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I.1 Introduction

The United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by MO HealthNet Managed Care Health Plans (MCHPs) and their contractors to participants of MO HealthNet Managed Care services. The CMS (42 CFR §433 and §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rule specifies the requirements for evaluation of Medicaid Managed Care programs. These rules require a desk review as well as an on-site review of each MCHP.

The State of Missouri contracts with the following MCHPs represented in this report:

- Blue-Advantage Plus (BA+)
- Children's Mercy Family Health Partners (CMFHP)
- Harmony Health Plan of Missouri (Harmony)
- HealthCare USA (HCUSA)
- Missouri Care (MO Care)
- Molina Healthcare of Missouri (Molina)

NOTE: The EQRO attempted to conduct an on-site review at the offices of Molina Healthcare of Missouri on June 25, 2012 and June 29, 2012. The EQRO review team was met at the reception desk of Molina on June 25, 2012 and told by its CEO and QI Director that Molina would not be participating in the on-site review portion of the EQR. As a result of their refusal to participate some areas of the EQR are adversely effected. This refusal impacts not only Molina's MCHP specific findings, but also impacts some of the "All MCHP" data reporting, as Molina's scores/rates are adding into the "All MCHP" data elements. The areas adversely effected by Molina's refusal to participate in the on-site review are detailed throughout this report and are summarized in the description of the activities analyzed below.

The EQR technical report analyzes and aggregates data from three mandatory EQR activities and one optional activity as described below:

1) Validating Performance Improvement Projects¹

Each MCHP conducted performance improvement projects (PIPs) during the 12 months preceding the audit; six of these PIPs were validated through a combination of self-selection and EQRO review. The final selection of PIPs to be audited was determined by the State Medicaid Agency (SMA; Missouri Department of Social Services, MO HealthNet Division (MHD)).

NOTE: Molina's refusal to participate in the on-site review adversely impacted their individual ratings/scores in the area of PIPs, as they did not supply additional PIP data, nor did they participate in the on-site evaluation session regarding PIPs. Additionally, any All MCHP ratings in the area of PIPs were adversely impacted by Molina's lower ratings/scores.

2) Validating Performance Measures²

The three performance measures validated were HEDIS 2011 measures of Annual Dental Visit (ADV), Childhood Immunization Status, Combo 3 (CIS3), and Follow Up After Hospitalization for Mental Illness (FUH).

NOTE: Molina's refusal to participate in the on-site review adversely impacted their ratings in the area of Performance Measures, due to their refusal to allow the EQRO to validate their information systems during the on-site review, all Molina Performance Measures received a rating of invalid.

3) MO HealthNet MCHP Compliance with Managed Care Regulations.³

The EQRO conducted all protocol activities, with the exception of the MCHP Compliance with Managed Care Regulations Protocol. The SMA conducted these activities and requested the EQRO to review them (Compliance Review Analysis); and

NOTE: Molina's refusal to participate in the on-site review adversely impacted their individual ratings/scores in the area of Compliance. Additionally, any All MCHP ratings in the area of Compliance were adversely impacted by Molina's low ratings/scores.

¹ Department of Health and Human Services. Centers for Medicare and Medicaid Services (2002). Validating Performance Improvement Projects: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002. Washington, D.C.: Author.

² Department of Health and Human Services. Centers for Medicare and Medicaid Services (2002). Validating Performance Measures: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002. Washington, D.C.: Author.

³ Department of Health and Human Services. Centers for Medicare and Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR §400, 430, et al., Final Protocol, Version 1.0, February 11, 2003. Washington, D.C.: Author.

4) Special Project – Case Management Record Review

The EQRO reviewed a random selection of Case Management files for each MCHP. These files were evaluated based on the requirements set forth in the MCHPs' contract with the SMA to deliver MO HealthNet Managed Care services.

NOTE: Molina's refusal to participate in the on-site review adversely impacted their ratings in the area of Case Management, as they did not participate in the interview process conducted with Case Management staff.

1.2 Validation of Performance Improvement Projects

For the Validating Performance Improvement Projects (PIP) Protocol, the EQRO validated two PIPs (one clinical and one non-clinical) for each MCHP that were underway during 2011. A total of 12 PIPs were validated. Eligible PIPs for validation were identified by the MCHPs, SMA, and the EQRO. The final selection of the PIPs for the 2011 validation process was made by the SMA in February 2012. The SMA directed the EQRO to validate the statewide PIP, Improving Oral Health. Below are the PIPs identified for validation at each MCHP:

BA+	Improving PCP Follow-Up After Non-Emergent ER Visits Improving Oral Health
Children' Mercy Family Health Partners	Improving Childhood Immunizations Improving Oral Health
Harmony Health Plan	Improving Asthma Management Improving Oral Health
HealthCare USA	Decreasing Non-Emergent/Avoidable Emergency Department Utilization Improving Oral Health
Missouri Care	Decreasing Emergency Department Utilization Improving Oral Health
Molina Health Care of Missouri	Reducing Repeat Emergency Department Visits for Members with Asthma Improving Oral Health

The focus of the PIPs is to study the effectiveness of clinical or non-clinical interventions. These projects should improve processes associated with healthcare outcomes, and/or the healthcare outcomes themselves. They are to be carried out over multiple re-measurement periods to measure: 1) improvement; 2) the need for continued improvement; or 3) stability in improvement as a result of an intervention. Under the State contract, each MCHP is required to have two active PIPs, one of which is clinical in nature and one non-clinical. Specific feedback and technical assistance was provided to each MCHP by the EQRO during the site visits for improving study methods, data collection, and analysis.

The EQR is tasked with reporting how Medicaid Managed Care participants access care, the quality of care participants receive and the timeliness of this care. CMS requests that the EQRO report on those three areas of care in each area of validation.

ACCESS TO CARE

Access to care was an important theme addressed throughout most of the PIP submissions reviewed. A major goal of the statewide non-clinical PIP is improved access to dental care. This goal was reflected in the individual PIP projects developed by each MCHP. Access to care was also an important focus in the clinical PIPs.

- Four MCHPs focused on assisting and educating members in developing PCP and specialist relationships in an effort to avoid the unnecessary use of the emergency department.
 - These PIPs had a significant focus on providing access to the correct medical provider through a variety of interventions. All the projects reviewed used the format of the PIP to improve access to care for members.
- Two projects focused on ensuring that members had adequate and timely access to asthma management services and childhood immunizations with the goal of providing access to primary and preventive care.
 - The on-site discussions with MCHP staff indicated that they realize that improving access to care is an ongoing aspect of all projects that are developed.

The PIPs based on the statewide topic of improving Oral Health utilized MCHP individualized interventions that informed or educated members about the availability of these services and encouraged increased utilization of healthcare services available.

QUALITY OF CARE

Topic identification was an area that provided evidence of the attention paid to providing quality services to members. Intervention development for PIPs also focused on the issue of quality services. The PIPs reviewed focused on topics that needed improvement, either in the internal processes used to operate the MCHP, or in the direct provision of services delivered. The corresponding interventions that addressed barriers to quality care and health outcomes were clearly evident in the narratives submitted, as well as in the discussions with MCHPs during the on-site review. These interventions addressed key aspects of enrollee care and services, such as

medication and treatment management; risk identification; use of additional case management and in-home service; monitoring provider access and quality services; and preventive care. These efforts exemplified an attention to quality healthcare services.

TIMELINESS OF CARE

Timeliness of care was a major focus of a number of the PIPs reviewed.

- The four projects addressing inappropriate use of the emergency department attempted to address the need for timely and appropriate care for members to ensure that services are provided in the best environment in a timely manner (Molina Healthcare of Missouri, Healthcare USA, BA Plus, and Missouri Care).
- Other projects focused on the subjects of timely utilization of preventive care such as improved access to childhood immunizations (Children's Mercy Family Health Partners) and managing members with asthma (Harmony Health Plan).

The need for timely access to preventive and primary health care services was recognized as an essential component of these projects. The MCHPs all related their awareness of the need to provide not only quality, but timely services to members. Projects reflected this awareness, as they addressed internal processes and direct service improvement. The PIPs related to improving Annual Dental Visits included a focus on obtaining timely screenings and recognized that this is an essential component of effective preventive care.

CONCLUSIONS

The MCHPs have made significant improvements in utilizing the PIP process since the EQRO measurement process began in 2004.

Figure I indicates the improvements the MCHPs have made in providing valid and reliable data for evaluation. There is an observed decline since the high rating of 97.10% in 2006.

NOTE: The lower overall rating can be partially attributed to Molina Healthcare of Missouri's refusal to participate in the onsite review during this year's review. At each onsite review, the MCHPs are given a preliminary analysis of the EQRO's ratings for the PIPs. The MCHPs were informed prior to the review that updates, including additional data to clarify or improve the PIP results, would be accepted at the onsite visit. Molina refused to participate in their scheduled onsite review and did not provide any additional information for their PIPs.

Figure I – Performance Improvement Project Validation Ratings, All MCHPs

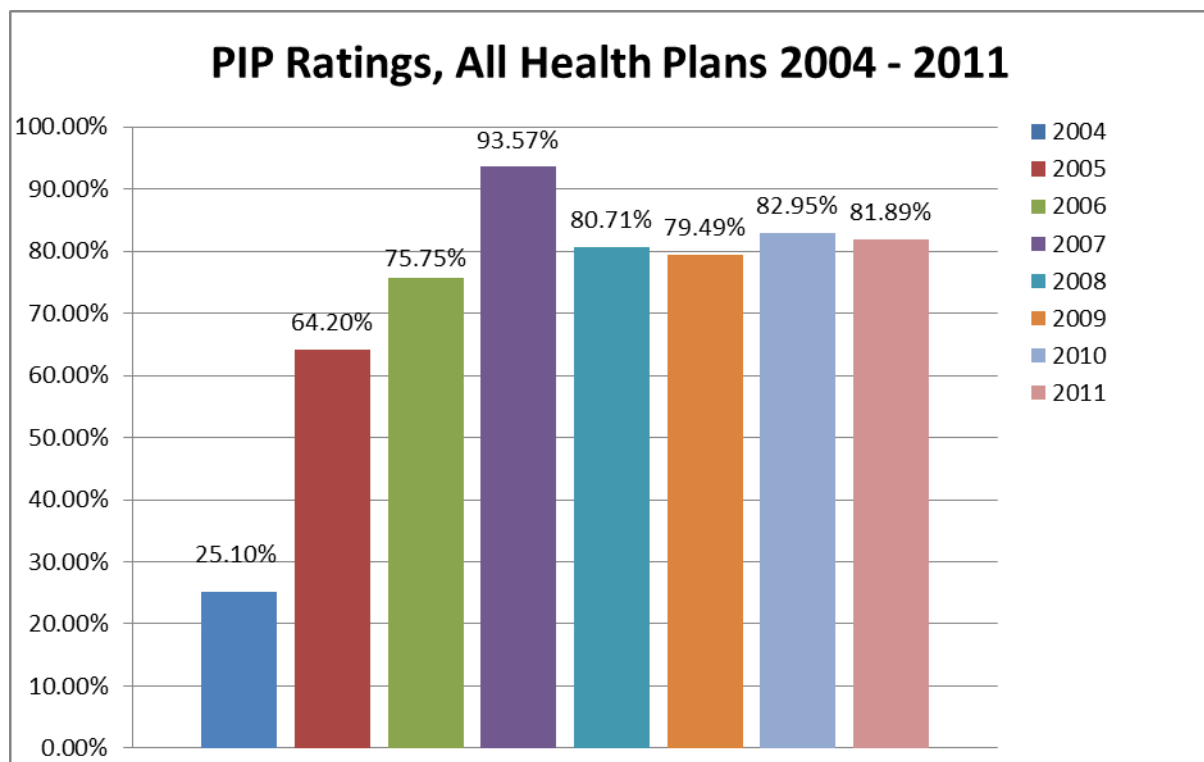
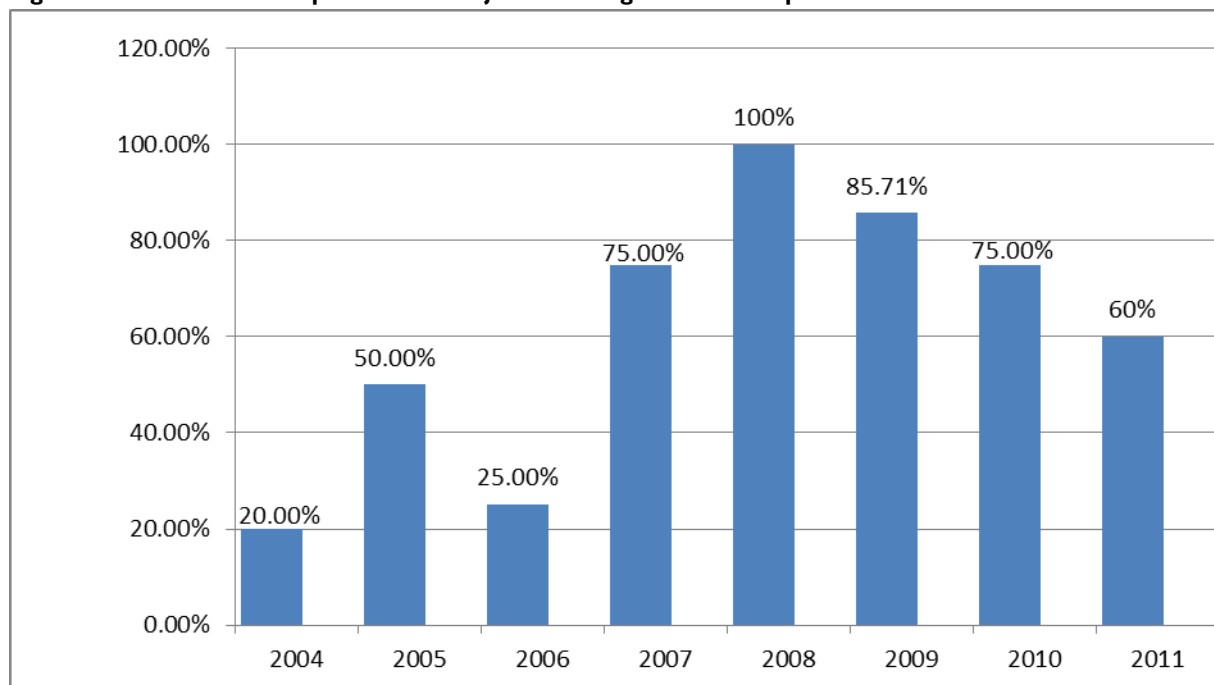


Figure 2, an essential element in validating these projects is represented, that is analyzing the projects ability to create sustained improvement. In 2004 this measure of the PIPs submitted was rated at 20% compliant. In 2009 this measure was rated at 85.71% for the projects mature enough to complete this evaluation. In 2010, only four PIPs were considered mature enough to evaluate their ability to produce sustained improvement. Of those four PIPs three were considered likely to sustain improvement, thereby the PIPs are only rated as 75% compliant for the 2010 review. This **declined** for the 2011 review to 60%, as five PIPs where considered mature enough to evaluate for sustained improvement and three of those five received ratings that showed sustained improvement.

Figure 2 – Performance Improvement Projects Meeting Sustained Improvement



1.3 Validation of Performance Measures

The Validating Performance Measures Protocol requires the validation or calculation of three performance measures at each MCHP by the EQRO. The measures selected for validation by the SMA are required to be submitted by each MCHP on an annual basis. The measures were also submitted by the State Public Health Agency (SPHA; Missouri Department of Health and Senior Services; DHSS). For the HEDIS 2011 evaluation period, the three performance measures selected for validation were Annual Dental Visits (ADV), Childhood Immunization Status, Combo 3 (CIS3), and Follow-Up After Hospitalization for Mental Illness (FUH). Detailed specifications for the calculation of these measures were developed by the National Committee for Quality Assurance (NCQA), a national accrediting organization for managed care organizations. The EQRO examined the information systems, detailed algorithms, MCHP extract files, medical records, and data submissions provided to the SPHA to conduct the validation activities of this protocol. The data reported to DHSS was based on MCHP performance during 2010.

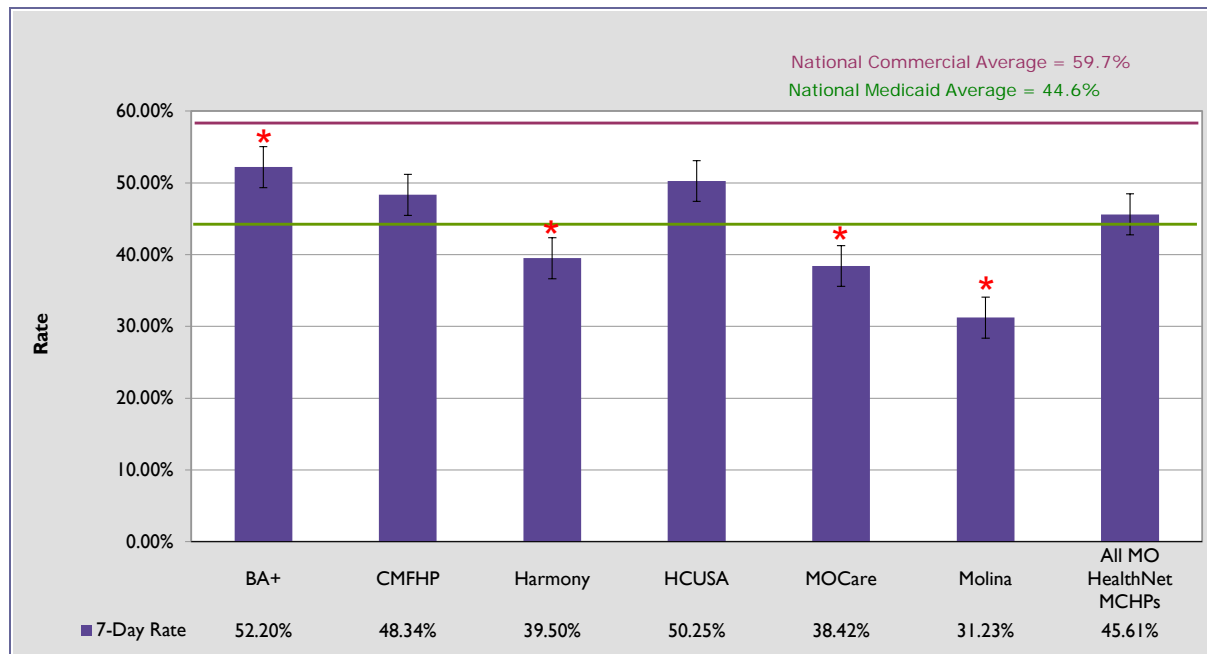
QUALITY OF CARE

The HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care received by MCHP members.

One MCHP was Fully Compliant with the specifications for calculation of this measure. Four MCHPs were substantially compliant with the specifications for calculation of this measure, while one received a rating of invalid for this measure.

For the 7-day follow up rate, three MCHPs (BA+, CMFHP and HCUSA) reported rates (52.20%, 48.34% and 50.25%, respectively) that were higher than the National Medicaid Average (44.6%) for this measure. The statewide rate for all MCHPs (45.61) was also higher than the National Medicaid Average.

Figure 3 - Managed Care Program HEDIS 2011 Follow-Up After Hospitalization for Mental Illness, 7-Day Rates

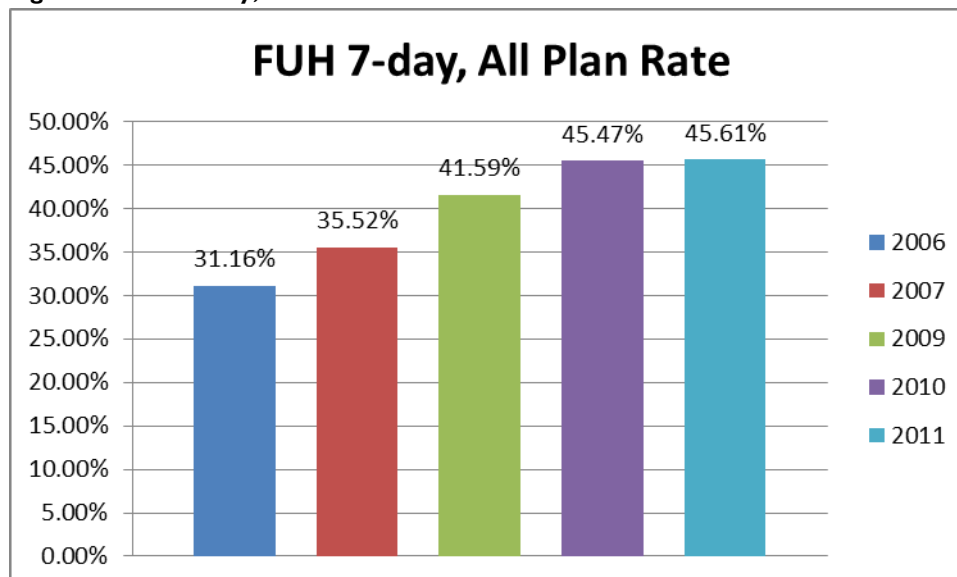


Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.

Sources: MCHP HEDIS 2011 DST; National Committee for Quality Assurance (NCQA).

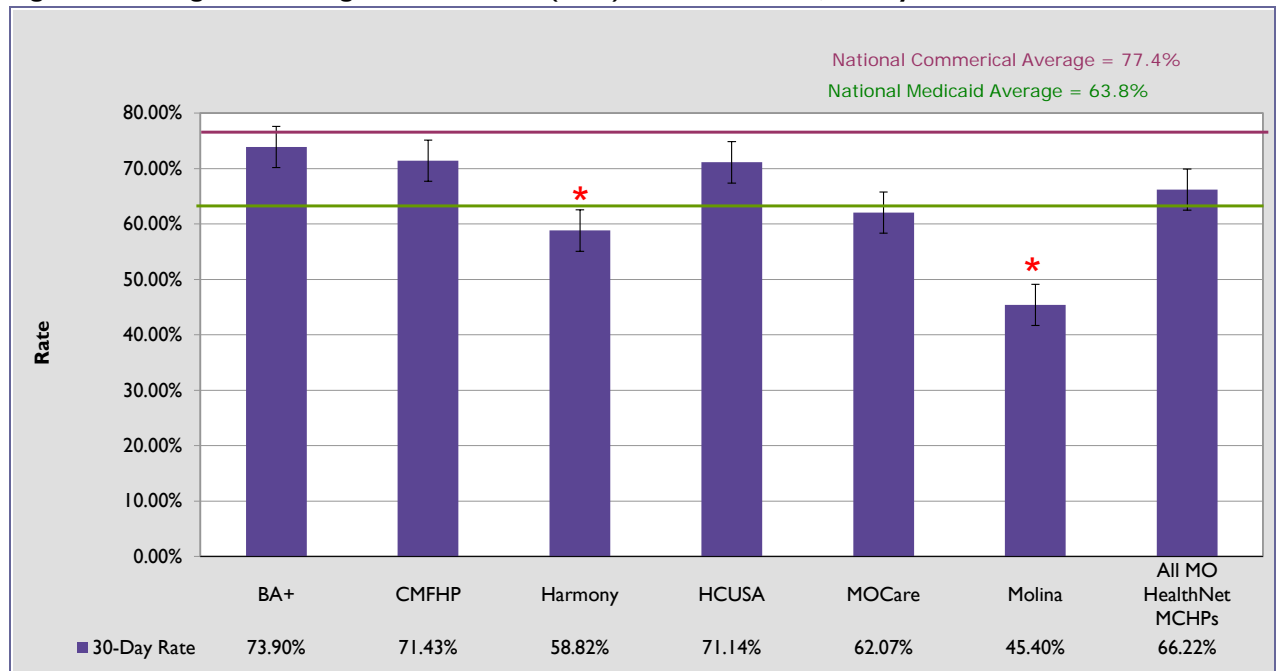
This measure was previously audited by the EQRO in audit years 2006, 2007, 2009, and 2010. The 7-Day reported rate for all MCHPs in 2011 (45.61%) was 14.45% points **higher** than the rate reported in 2006 (31.16%); it is 0.14% points **higher** than the rate reported in 2010 (45.47%).

Figure 4 – FUH 7-Day, All MCHPs



For the 30-day follow up rate, three MCHPs (BA+, CMFHP, and HCUSA) all reported rates (73.90%, 71.43%, and 71.14% respectively) that were above than the National Medicaid Average (63.8%) for this measure. The overall MO MCHP rate (66.22%) was also **higher** than the National Medicaid Average.

Figure 5 - Managed Care Program HEDIS 2011 (FUH) for Mental Illness, 30-Day Rate

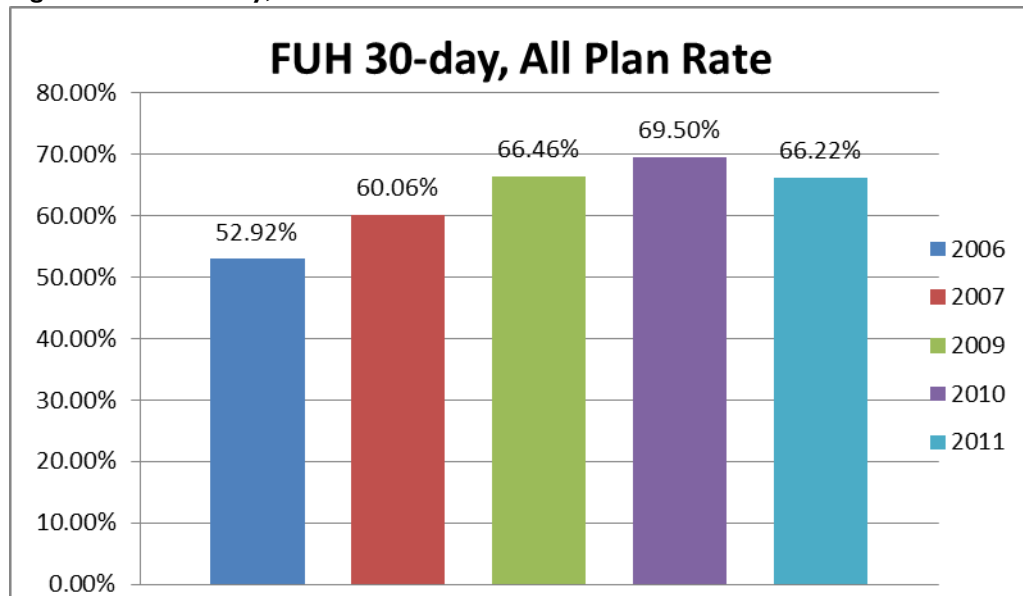


Note: Error bars on the y-axis represent 95% confidence intervals.

Sources: MCHP HEDIS 2011 DST; National Committee for Quality Assurance (NCQA)

This measure was previously audited by the EQRO in audit years 2006, 2007, 2009, and 2010. The 30-Day reported rate for all MCHPs in 2011 (66.22%) was a decrease from the rate reported in 2010 (69.50%), but remains a 13.3% point increase overall since the rate reported in 2006 (52.92%).

Figure 6 – FUH 30-Day, All MCHPs



From examination of these rates, it can be concluded that MCHP members are receiving a quality of care comparable to or higher than other Medicaid participants across the country within the 30-day timeframe the area of Follow-Up After Hospitalization for Mental Illness, but the quality of care received is not quite as high within the 7-day timeframe. In both timeframes, members are receiving a lower quality of care than the average National Commercial member. However, based on the upward trend in the rates reported, the quality of care for Follow-Up After Hospitalization for Mental Illness has significantly increased over time in Missouri for both the 7-day and 30-day timeframes, despite a slight fall in the most recent 30-day timeframe rate.

ACCESS TO CARE

The HEDIS 2011 Annual Dental Visit measure is categorized as an Access/Availability of Service measure and aims to measure the access to care received. Members need only one qualifying visit from any appropriate provider to be included in this measure calculation.

For the Annual Dental Visits measure, five of the six MO HealthNet MCHPs reviewed were substantially compliant with the calculation of this measure, one MCHP was rated as invalid.

The Annual Dental Visits measure has been audited in the 2007, 2008, 2009, 2010, and 2011 external quality reviews. Over the course of these review periods, the rates for all MCHPs have improved a total of 9.34%, from 32.50% in 2007 to 41.84% in 2011. Although the rates have increased for the Annual Dental Visit measure, none of the MCHPs reported a rate in 2011 higher than the National Medicaid Average of 47.8%, although one MCHP (CMFHP) was close at 47.74%.

Figure 7 – Managed Care Program HEDIS 2011 Annual Dental Visit, Administrative Rates

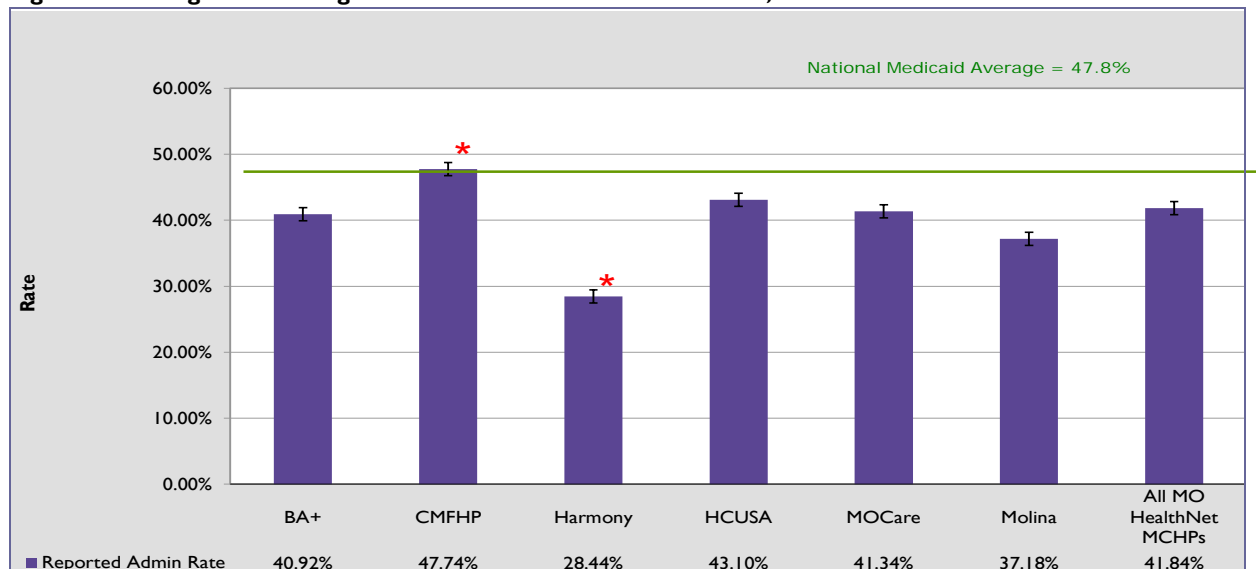
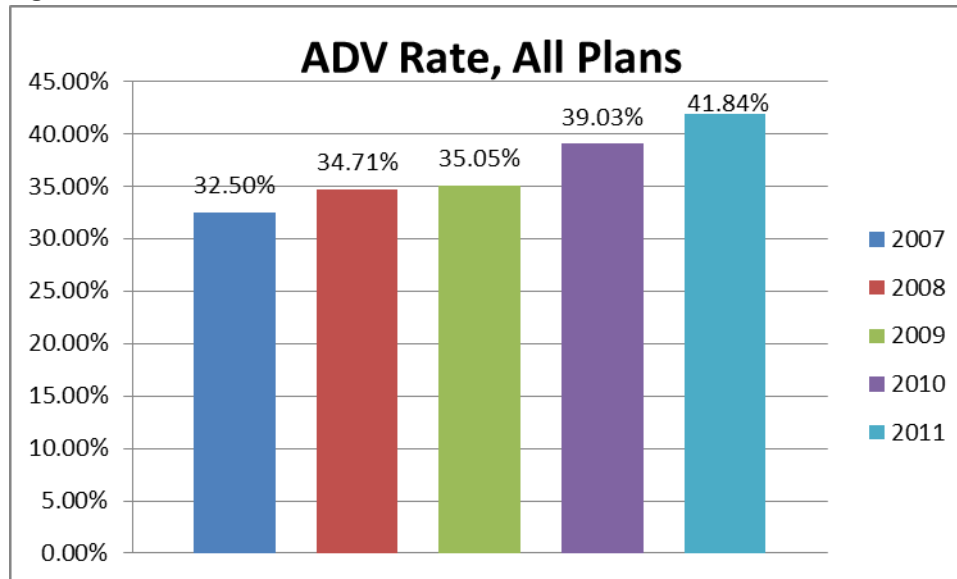


Figure 8 – ADV Rate, All Plans



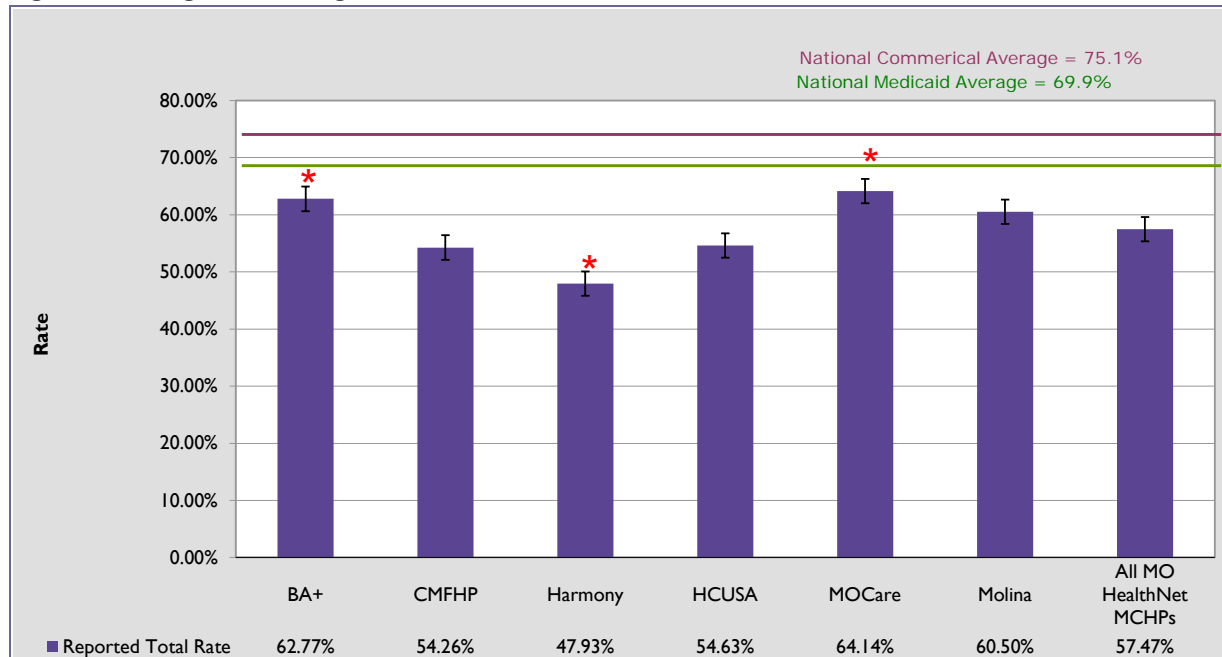
This trend shows an increased level of dental care received in Missouri by members, illustrating an increased access to care for these services for the HEDIS 2011 measurement year.

TIMELINESS OF CARE

The HEDIS 2011 Childhood Immunizations Status measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received. To increase the rates for this measure, members must receive a series of services within a very specific timeframe (i.e. prior to age 2).

For the Childhood Immunizations Status measure, five of the six MCHPs reviewed were substantially compliant with the calculation of this measure, one MCHP was rated as invalid.

Figure 9 - Managed Care Program HEDIS 2011 Childhood Immunizations Status Combo 3, Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance.

Sources: MCHP HEDIS 2011 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Although Combination 2 for this measure was audited in 2005, the Childhood Immunizations Status, Combination 3 measure has not previously been audited by the EQRO. Therefore, no valid trend data is available for the MO HealthNet Managed Care population. None of the MCHPs reported a rate in 2011 higher than the National Medicaid Average of 69.9%.

This illustrates a timeliness of care for immunizations delivered to children in Missouri that is lower than the timeliness of care received by other Medicaid members across the nation.

1.4 MO HealthNet MCHP Compliance with Managed Care Regulations

The purpose of the protocol to monitor MCHP Compliance with Managed Care Regulations is to provide an independent review of MCHP activities and assess the outcomes of timeliness and access to the services provided. The protocol requires the utilization of two main sources of information to determine compliance with federal regulations. These sources of information are document review and interviews with MCHP personnel. This combination of information was designed to provide the SMA with a better understanding of organizational performance at each MCHP.

The policy and practice in the operation of each MCHP was evaluated against the seventy (70) regulations related to operating a Medicaid managed care program. The regulations were grouped into three main categories: Enrollee Rights and Protections, Quality Assessment and Improvement, and Grievance Systems. The category of Quality Assessment and Improvement was subdivided into three subcategories: Access Standards, Structure and Operation Standards, and Measurement and Improvement. Initially, the SMA reviewed each MCHP's policy to determine compliance with the requirements of the Managed Care Contract. These determinations and their application to the requirements of the federal regulations were assessed by the EQRO.

The 2009 report was a full compliance review. This year's compliance review is a follow up to that review and includes a follow up to the 2006 and 2010 review years which included a case review of Grievance and Appeal files. The SMA reviewed current policies and procedures to ensure they were in compliance with the current contractual requirements, as well as federal regulations. The EQR Compliance Review focused on implementation of policies and procedures, as required in the Grievance and Appeals and Case Management processes. The review included case record reviews and interviews with Grievance and Appeal staff, Case Management staff, and Administrative staff. Again, interviews did not occur with Molina Healthcare of Missouri as they refused to participate in the scheduled onsite review.

The results of the Case Management review will be reported in another section of this report as a "Special Project". The interview tools were based on information obtained from each MCHPs' 2011 Annual Reports to the SMA and the SMA's Quality Improvement Strategy.

The review process included gathering information and documentation from the SMA about policy submission and approval, which directly affects each MCHP's contract compliance. This information was analyzed to determine how it related to compliance with the federal regulations. Next, interview questions were prepared, based on the need to investigate if practice existed in areas where approved policy was or was not available, and if local policy and procedures were in use when approved policy was not complete. The interview responses and additional documentation obtained on-site were then analyzed to evaluate how they contributed to each MCHP's compliance. All information gathered was assessed, re-reviewed, and translated into recommended compliance ratings for each regulatory provision.

QUALITY OF CARE

For all the MCHPs who participated in the onsite review, all of the 13 regulations for Enrollee Rights and Protections were 100% "Met." These regulations include:

- Communicating Managed Care Members' rights to respect, privacy, and treatment options were primary and compliant.
- Communicating, orally and in writing, in the member's native language or with the provision of interpretive services is an area of strength for all MCHPs.
- The MCHPs recognized these requirements are essential to create an atmosphere of delivering quality healthcare to members.
- The MCHPs maintained an awareness of and appropriate responses to cultural and language barriers concerning communication in obtaining healthcare.
- The MCHPs responded to physical, emotional and cultural barriers experienced by members with diligence and creativity.
- The MCHPs demonstrated an awareness of Enrollee Rights and Protections by having standards and practices in place that were compliant and evident in discussions with staff who interact directly with members. The attention to ensuring quality care was apparent throughout each of the MCHPs.

For all the MCHPs who participated in the onsite review, all of the 10 regulations for Structure and Operations Standards were 100% "Met." These included provider selection, and network maintenance, subcontract relationships, and delegation. The MCHPs had active mechanisms for oversight of all subcontractors in place. This is the second year in a row that these five MCHPs maintained a 100% rating in this set of regulations. These MCHPs articulated their understanding

that maintaining compliance in this area enabled them to provide quality services to their Managed Care members. These regulations include:

- Provider selection and network maintenance, subcontract relationships, and delegation.
- The MCHPs had active mechanisms for oversight of all subcontractors.
- The MCHPs improved significantly in compliance with this set of regulations and articulated their understanding that maintaining compliance in this area enabled them to provide quality services to their Managed Care members.

Molina Healthcare of Missouri refused to participate in the scheduled onsite review at their offices in St. Louis, MO on Monday, July 25, 2012. Due to this decision, the EQRO could not effectively evaluate the Quality of Care delivered to the Molina members.

ACCESS TO CARE

Five of the six MCHPs' compliance with the 17 federal regulations concerning Access Standards **improved** or remained **consistent** during this year's review. Two MCHPs were 82.35% compliant, two MCHPs were 76.5% compliant and one was found to be 70.6% compliant. One MCHP (Molina) received a much lower rating for compliance with Access Standards of 64.71%, this is largely attributable to their lack of participation in the onsite review.

Although the EQRO observed that most of the MCHPs had active case management services in place, the records requested did not always contain information to substantiate these observations. Each MCHP described measures they used to identify and provide services to MO HealthNet Managed Care Members who have special healthcare needs. Five of the MCHPs could describe efforts to participate in community events and forums to provide education to members regarding the use of PCPs, special programs available, and how to access their PCP and other specialist service providers that might be required. The MCHPs were crucially aware of their responsibility to provide access to care and services, and to communicate complete information on this topic to their members. One area of concern is care coordination. Although all six MCHPs had all required policy in place, none of them were able to demonstrate through chart review that they had fully compliant care coordination processes in place.

TIMELINESS OF CARE

Only three of the 12 regulations for Measurement and Improvement were 100% “Met.” However, only one of the six MO HealthNet MCHPs met all of the regulatory requirements. All five of the MCHPs that participated in the onsite review adopted, disseminated and applied practice guidelines to ensure sound and timely healthcare services for members. These MCHPs used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilization management.

Several MCHPs continue to use member and community based quality improvement groups to assist in determining barriers to services and methods to improve service delivery. The Case Management departments reported integral working relationships with the Provider Services and Relations Departments of the MCHPs. This was not always evident in the documentation reviewed. All front line staff and administrators interviewed exhibited a commitment to relationship building, as well as monitoring providers to ensure that all standards of care were met and that good service, decision-making, and sound healthcare practices occurred on behalf of members. The MCHPs, that participated in the onsite review, all provided examples of how these relationships served to ensure that members received timely and effective healthcare. The MCHP staff would contact providers directly to make appointments whenever members expressed difficulty in obtaining timely services.

Only two of the 18 regulations for Grievance Systems were 100% “Met” for all of the MCHPs. These regulations all pertained to the written policy and procedure of the MCHPs. All five of the MCHP’s who made Grievance and Appeal files available to the EQRO during the onsite review improved greatly in the compliance ratings they received in this category. The practice at these five MCHPs was much closer to matching the written policy than in the prior year’s review.

MCHPs remained invested in developing programs and providing services beyond the strict obligations of the contracts. Preventive health and screening initiatives exhibited a commitment to providing the best healthcare in the least invasive manner to their members. Partnerships with local universities and medical schools provided opportunities to obtain cutting-edge and occasionally experimental treatment options, which would not otherwise be available to members. The MCHPs observed that these efforts combined to create a system that allowed members timely access to quality healthcare.

The EQRO was asked by the SMA to focus more closely on the area of Grievances and Appeals during this follow-up Compliance review. The EQRO developed a methodology whereby, a sample of Grievance and Appeal files were reviewed on-site by the EQRO Project Director. A listing of all Grievance and Appeals, as reported by the MCHPs to the SMA, was obtained for 4Q2011. A number of these files were then randomly selected for review at the on-site visit. Each MCHP was provided a listing of the files to be reviewed one week prior to the on-site reading day (1/2 day of review).

Once on-site, these files were reviewed for compliance with Subpart F of the regulatory provisions for Medicaid managed care (Grievances and Appeals) and the MCHPs' contract for the provision of MO HealthNet services with the SMA.

Conclusion

Five of the six MCHPs experienced some level of noncompliance with the regulations related to grievances and appeals (see Table 20). Although all plans had policy that was complete and approved by the SMA, at most of the MCHPs, a review of the files showed a lack of adherence to those policies and procedures. Although Molina did not participate in the onsite review, the EQRO reviewed all of the Grievance and Appeals files that they supplied to the EQRO as of the date of the scheduled on-site review. Twenty-one files were not received as of that date and were therefore not reviewed.

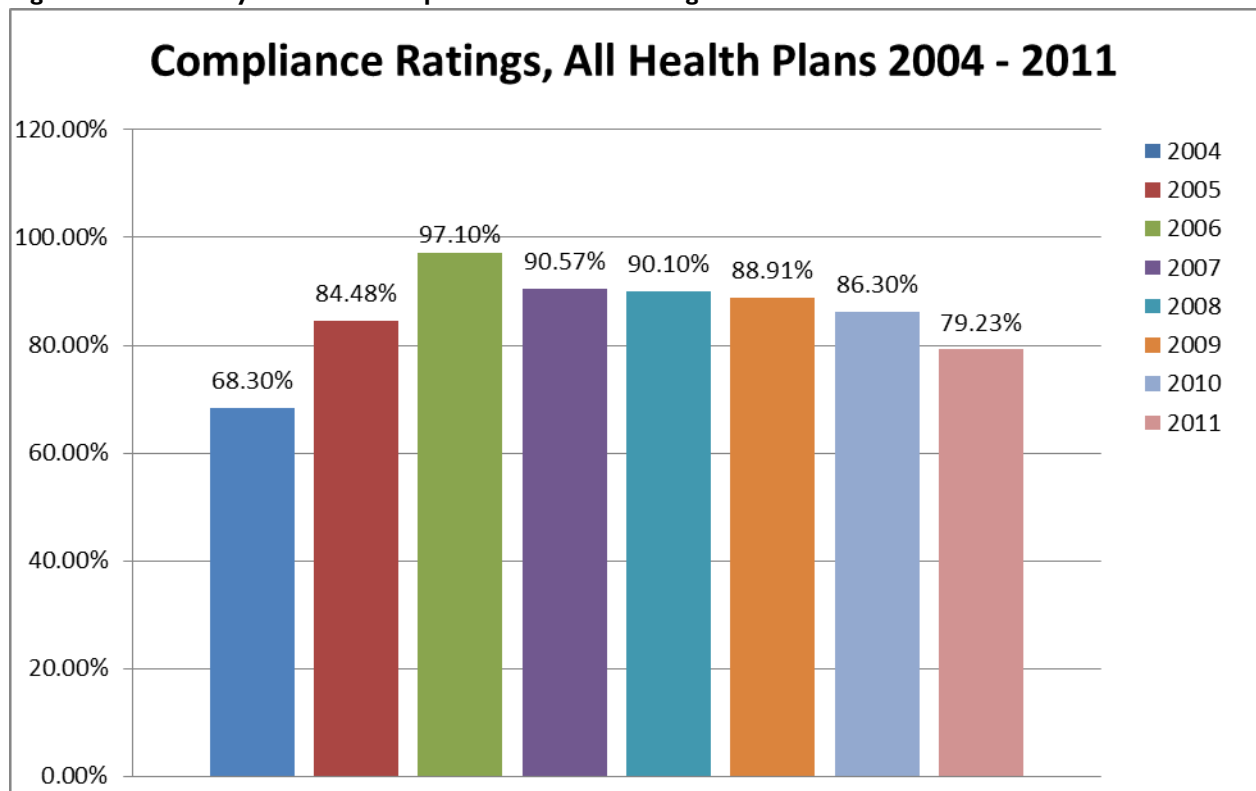
Table 1 – Grievance and Appeals records reviewed by MCHP

MCHP	# of records reviewed	# with issues	% with issues	% Correct
Blue-Advantage Plus	30	2	6.67%	93.33%
CMFHP	32	6	18.75%	81.25%
Harmony	39	6	15.38%	84.62%
HCUSA	30	1	3.33%	96.67%
MO Care	40	0	0.00%	100.0%
Molina	50	21	42.0%	58.0%
Statewide rate	221	36	16.29%	83.71%

CONCLUSIONS

The MCHPs have shown significant improvement in their ability to meet the requirements of compliance with the federal regulations. Initially in 2004 the MCHPs did not have complete and approved written policies and procedures and MCHP processes did not exhibit compliance with contractual and regulatory requirements. In subsequent measurements, the MCHPs made concerted efforts to complete policy and procedural requirements. In 2007-2011, the review examined not only the written policy, but also conducted interviews to identify if the activities of front line and administrative staff were in compliance. The MCHPs have used previous EQRs to ensure that compliant policies are in place, and continue their efforts to ensure compliant and member focused procedures.

Figure 10 – Summary of MCHP Compliance with Federal Regulations



A downward trend in the Compliance Ratings, as detailed in Figure 10, can be attributed to the MCHPs inability to demonstrate that they had fully compliant care coordination and/or grievance and appeals processes in place. All six MCHPs state that complete care coordination is an area where they seek improvement. Additionally, all six MCHPs experienced some level of noncompliance with the regulations related to grievances and appeals. Although all plans had policy that was complete and approved by the SMA, at most of the MCHPs, a review of the grievance and appeals files showed a lack of adherence to those policies and procedures.

Additionally, the lack of participation in the onsite review by Molina skews the compliance ratings in a negative direction. If Molina is removed from the equation, the overall Compliance rating for All MCHP's is 87.89% total Compliance.

I.5 MO HealthNet MCHP Special Project – Case Management Performance Review

INTRODUCTION

The MO HealthNet Division (MHD) asked the EQRO to conduct a special project to follow up on the Managed Care Health Plans' (MCHP) compliance with federal regulations regarding quality, timeliness, and access to health care services related to the provision of case management services. The objective of this special project is to complete an in-depth follow-up review of Case Management by assessing the MCHPs' improvement in Case Management service delivery and recording keeping. The EQRO also evaluated the MCHP's compliance with the federal regulations and Managed Care contract as it pertained to Case Management.

The focus of this review was:

- Assessing the MCHPs' attention and performance in providing case management to pregnant members, children with special health care needs, and children with elevated blood lead levels;
- Evaluating compliance with the Managed Care contract; and
- Exploring the effectiveness of case management activities provided by the MCHPs on cases they report as open in their system.

OBSERVATIONS AND CONCLUSIONS

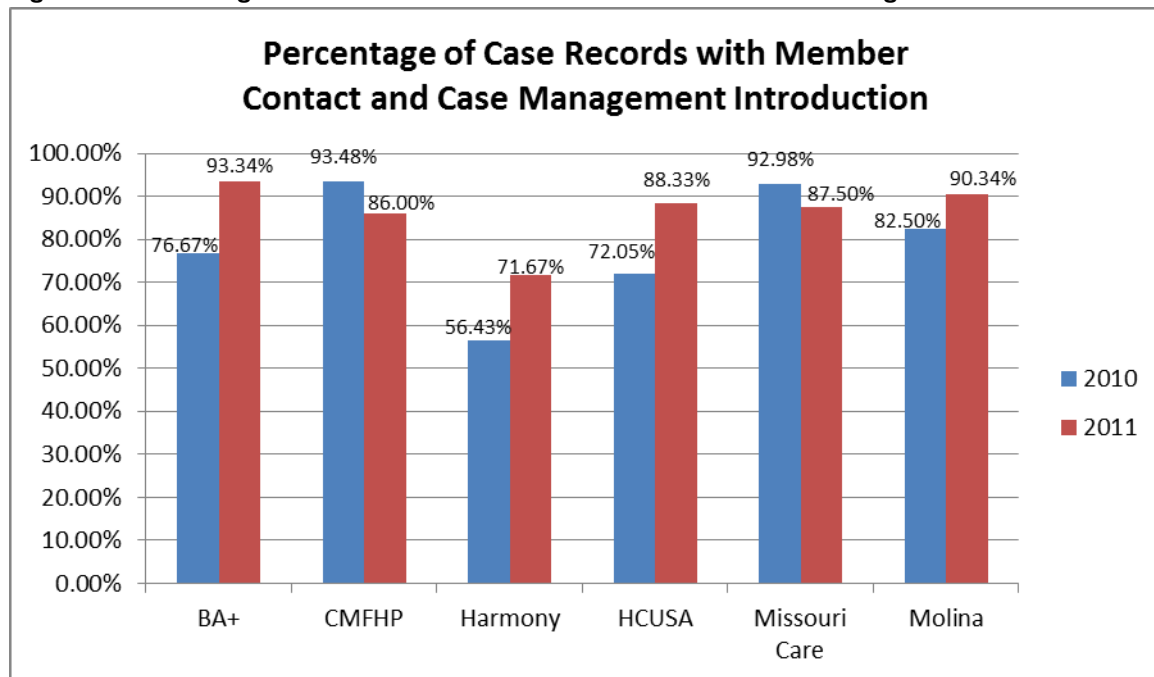
INTRODUCTION TO CASE MANAGEMENT

There are four standards used to assess the category of Introduction to Case Management. The records and recording must include:

1. Identifying information used to locate and maintain contact with the member;
2. Case opening – after receipt of referral was a case opened for assessment and service delivery;
3. Introduction to Case Management – did the case manager explain the case management process to the member; and

4. Acceptance of Services – did the member indicate they agreed to the MCHP providing case management services, thereby allowing on-going involvement.

Figure 11 - Percentage of Case Records with Member Contact and Case Management Introduction



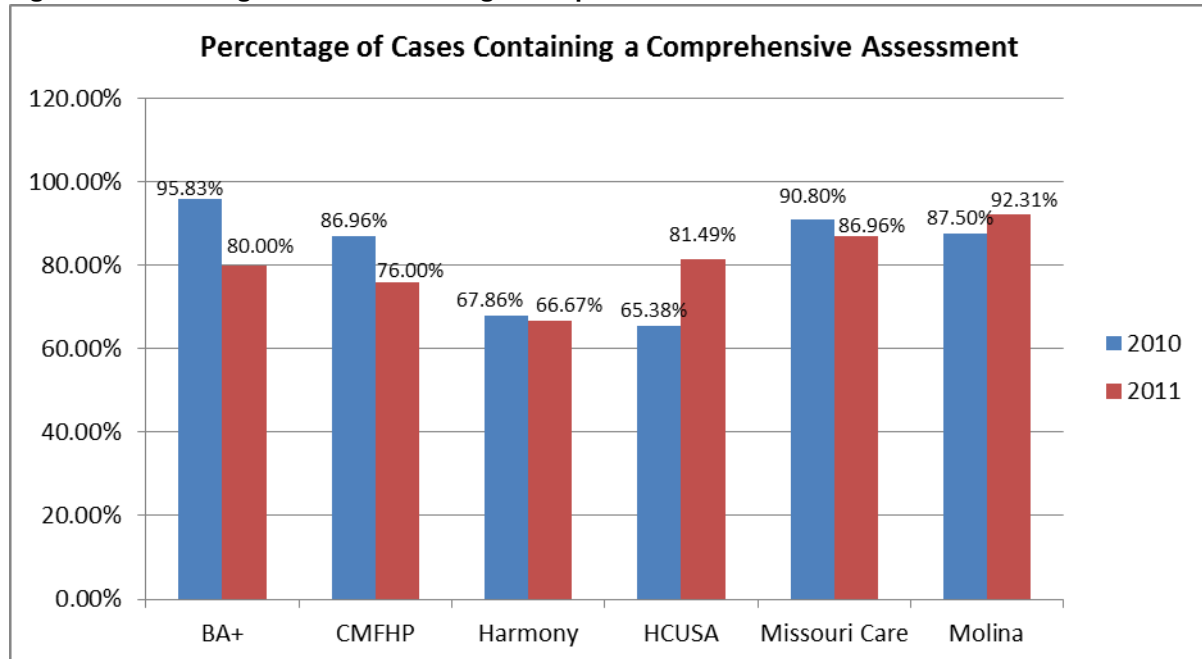
- Obtaining referrals, locating members, introducing them to the case management process, and eliciting their acceptance of case management services are essential functions for case managers.
 - Four of the six MCHPs (BA+, Harmony, HCUSA, and Molina) improved in all four standards from 2010 to 2011.
 - Two MCHPs' percentages declined (CMFHP and Missouri Care). Both achieved 100% compliance in the area of obtaining identifying information and opening cases during the 2010 review.
 - EQR case reviewers identified instances where efforts to regain contact with members were limited. In these cases, the case manager did not explore alternative methods of contact, such as contact with provider offices to request current demographic information.
- Case managers receive referrals from a variety of sources internal and external to the MCHP.
 - Members have the option of declining case management services. In most of the records reviewed, members contacted welcomed the support that case management offers. In the majority of instances case management services were accepted.
- Case managers are required to explain the nature of the case management relationship, the contact they will have with the member and the services available. Case managers must request

approval to discuss the case with a third party, if appropriate, discuss the availability of a complaint process, and explain any contacts with the providers involved.

- Cases that were referred to several MCHPs (Molina, HCUSA, and Harmony) due to Elevated Blood Lead Levels (EBLL) indicated no member contact.

ASSESSMENT

Figure 12 - Percentage of Cases Containing a Comprehensive Assessment



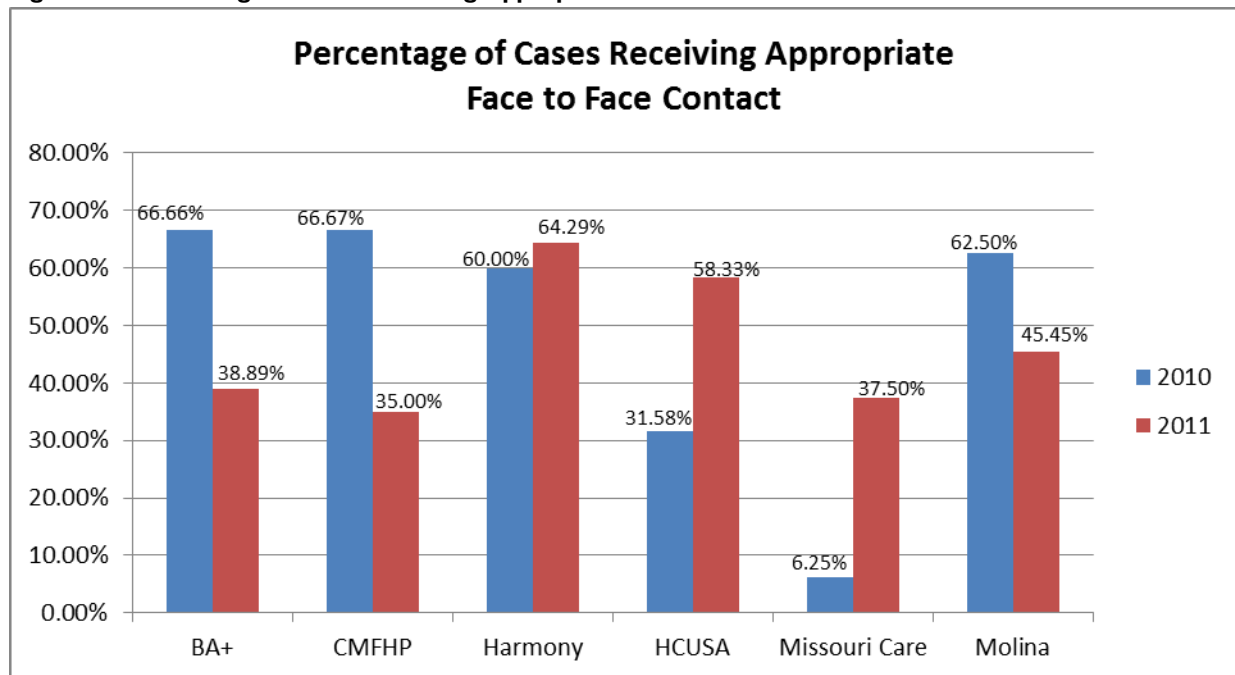
The standards used to evaluate the assessment of the member's service needs include:

1. Completion within specified time frames; and
 2. Inclusion of a comprehensive assessment in the file.
- All records and recording must include an assessment tool or questions.
 - The records from two MCHPs (HealthCare USA, Molina) provided more assessment information than in the previous review.
 - In four of the MCHP's records (BA+, CMFHP, Harmony, and Missouri Care), the assessment tool or questions were found in fewer case records in 2011 than in 2010.
 - Case notes mentioned the assessment process, in some records, but the actual assessment tool or questions/responses were not available.
 - These assessments are to be comprehensive in nature for all MCHPs. This requirement did not improve in 2011.

- Although the assessments are used to create a care plan for the member, any direct extrapolation of information into case activities was limited.

FACE TO FACE CONTACTS

Figure 13 - Percentage of Cases Receiving Appropriate Face to Face Contacts



- The Managed Care contract contains standards that require specific face to face contacts for members in lead case management, members who are pregnant, and in other cases as deemed necessary.
 - Three MCHPs showed improvement in this area (Harmony, HCUSA, and Missouri Care) from the 2010 review.
 - Three MCHPs had a decrease in the number of cases where face to face contacts occurred (BA+, CMFHP, and Molina).
 - Even though there was some improvement in this area in 2011, the highest percentage of cases receiving required face to face contact was only 64.29%.
- One MCHP (Harmony) began using a nurse case manager housed in their St. Louis office who worked primarily in the field making home visits or meeting members in a setting they chose.
 - This case manager carried the cases of all pregnant women in Harmony's Missouri market. The cases reviewed indicated the ability to maintain contact with members throughout their pregnancy. The case manager was able to establish a strong working relationship with the

members and provide services, both medical and other community-based referrals, directly meeting their needs.

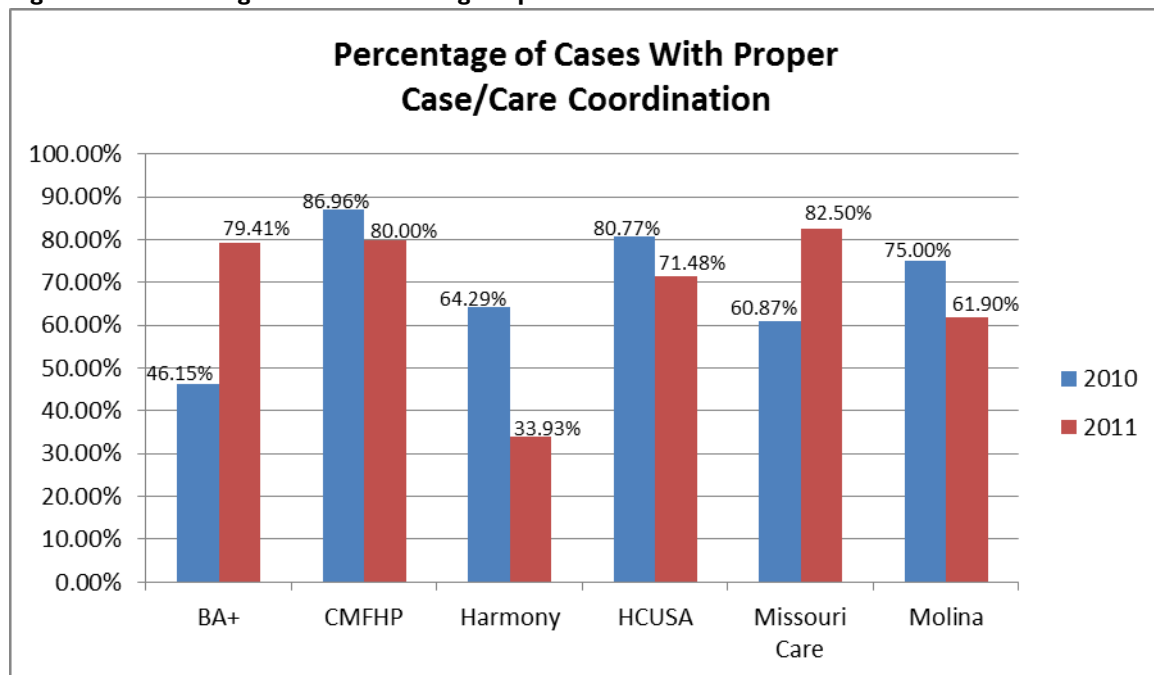
- This model of case management, in the home or natural environment of the member, provided examples of a method that could overcome many barriers identified by MCHPs in the delivery of case management services.
- Case managers at four MCHPs (BA+, CMFHP, HCUSA, and Harmony) reported making face to face contacts themselves. With the exception of the OB case manager at Harmony, this was described as occurring “as needed” or “occasionally.”

CASE/CARE COORDINATION

There are two standards used to assess the category of case/care coordination.

1. Case managers are to recognize the need for coordination of services with other providers involved with the members.
2. Case managers are to ensure that the availability of behavioral health services is discussed with the member.

Figure 14 - Percentage of Cases Involving Proper Case/Care Coordination



- Recognizing the need for care/case coordination.
 - Two MCHPs (BA+ and Missouri Care) improved in both areas in 2011.

- The case managers clearly identified the need to report on efforts to contact home health providers, case managers from public health agencies, the Family Support Division or the Children's Division.
 - These case managers actively discussed the need for behavioral health services and made appropriate referrals.
 - These activities were captured in progress notes, and were not just a check box on an initial assessment tool.
- Two MCHPs (CMFHP and HCUSA) improved only in the area of care coordination in 2011.
- Case managers failed to discuss the need for or availability of behavioral health services other than mentioning this during an initial assessment.
- Cases were reviewed that included assessment tools indicating a history of depression or other mental health issues. Behavioral health was not addressed with these members and no referrals were evident in the information available.

The EQR is tasked with reporting how Medicaid Managed Care participants access care, the quality of care participants receive and the timeliness of this care. CMS requests that the EQRO report on those three areas of care in each area of validation.

QUALITY OF CARE

Introduction to Case Management

- When members are properly introduced to and engaged in case management the quality of service delivery improves. Case managers maintain contact and in some cases advocate for extraordinary services to meet members healthcare needs.
- In 2010 and again in 2011 reviewers saw examples of case management services that provided referrals and communicated with the physicians or their staff regularly. These case managers assisted members in achieving their goals and stabilizing their health care conditions. They used MCHP sponsored services, linked members to community resources and ensured the outcome of improved member health.

Care Planning

- In cases opened for long periods of time the records included updated care plans. Case notes included references to issues that were resolved, new areas of concern, and why case management services continued for the member.

PCP Involvement

- In case records indicating contact with the physician's office, case notes reflected a depth of knowledge about the member that appears essential in providing comprehensive case management.
 - These cases included many contacts with the physician's nurse or nurse practitioners.
 - Physicians responded directly to inquiries and questions from the case managers.
 - When contacts occur the case notes indicate better and more complete service delivery.

Face to Face Contacts

- The Harmony OB Case Manager's model of service delivery, as described in an earlier section (Face to Face Contacts), greatly enhanced members' quality of care. The members receiving this service attended more prenatal visits and delivered healthier babies, as witnessed by data collected by the MCHP. This model should be considered by all MCHPs.

Opportunities for Improvement

Assessment

- Assessment tools are computer generated asking standardized questions. Case notes did not reflect a correlation between the information obtained in the assessment process and the direction of case management services.

Care Planning

- The care plans are often system generated directly from the assessment tool. Information provided did not reflect discussion with the member about their true needs, and how this process was going to positively impact the care or services offered to them.
- Informing the PCP, or including them in care plan development, was minimal.

Transition at Closing

- Completing and communicating a transition plan with members that provide direction and information was rarely observed.
- Informing the PCP and other providers when case management ceases, which is a component of effective transition planning, did not occur as required.

➤ **Lead Case Management**

- It was observed that in the area of lead case management, member's quality of care was negatively affected.
- Twenty-six (26) cases opened as the result of a referral for elevated blood lead levels (EBLL) were reviewed.
 - Eighteen (18) of the lead case management cases raised concerns.
 - Home visits or face to face contacts were not authorized or arranged as required.
 - Few or no contacts were made with the member or the member's parent/guardian.
 - These issues were noted in lead case management by three MCHP's (Harmony, Molina and HCUSA).

ACCESS TO CARE

Introduction to Case Management

- Access to care was enhanced in the cases where case managers actively worked with families. In a number of cases reviewers observed creative and relentless efforts to locate members. Some of the MCHPs utilize contractors who "drive by" a member's reported address to learn if the member is actually living there and/or to learn if forwarding information is available.

Percentage of Case Records Containing Appropriate Provider & Service Referrals

- Access is improved by case managers' efforts to obtain services, community based or by providers, which uniquely met members' needs.
- A member needing on-going durable medical equipment never seemed to have an authorization in the system. The case manager closely followed the MCHP system, called the provider, and made sure that the supplies were delivered as needed.

Contact with Members

- Access was improved when case managers remained in contact with members receiving OB services. This ensured members' access to services such as a follow-up with their OB-GYN and a first visit to the pediatrician for the baby.

Opportunities for Improvement

Introduction to Case Management

- Consistent attempts to contact members, which are essential to ensuring good access to healthcare services, were not evident in a number of cases at each MCHP.

Contact with Members

- Case managers lost contact with members who had newborns. When they encounter problems contacting the members, case management services end and no transition plan is developed.

Case/Care Coordination

- Lack of consistent case/care coordination practices was observed. This created some duplication of services, and failed to maximize MCHP resources.
- A lack of commitment to members who are difficult to locate or contact continues.

TIMELINESS OF CARE

PCP Involvement

When case managers are actively serving a member; fewer emergency department visits occur, members attend scheduled appointments, and assistance is provided to ensure that members see specialists in a timely fashion.

- When case management occurred throughout the OB cases reviewed, including the sixty (60) days postpartum, follow-up visits with the OB and initial pediatrician appointments for the newborn occurred within these time frames. These parents often enrolled their babies with the MCHP so ongoing preventive care could occur.

Transition at Closing

- Lack of effort to create transitional planning or follow-up with the member creates a situation where significant healthcare issues resurface due to unachieved goals.
 - Case Managers assert that after members' health care needs are met, the member loses interest in case management and no longer returns calls or responds to letters requesting they contact the case manager.
 - The case is then closed using the approved standard closing letter with no case specific plan included.

Care Planning and PCP Involvement

- Information sharing with PCP offices and sending a letter at case closing does not occur as required.
 - Case managers' lack of attention to this aspect of service delivery negatively impacts members' ability to obtain needed services in a timely manner.

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2.0 VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

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2.1 Definition

A Performance Improvement Project (PIP) is defined by the Centers for Medicare and Medicaid Services (CMS) as “a project designed to assess and improve processes, and outcomes of care...that is designed, conducted and reported in a methodologically sound manner.” The Validating Performance Improvement Projects Protocol specifies that the EQRO conduct three activities in the validation of two PIPs at each MCHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. The State Medicaid Agency (SMA: the Department of Social Services, MO HealthNet Division) elected to examine projects that were underway during the preceding calendar year 2011. This selection included evaluating the Statewide Project entitled Improving Oral Health. The aggregate report was evaluated, and each individual MCHP’s response and interventions were examined

2.2 Purpose and Objectives

The purpose and objectives of the present review were to evaluate the soundness and results of PIPs implemented by MCHPs during the calendar year 2011. The MCHPs were to have two active PIPs in place, one clinical and one non-clinical. The validation process examines the stability and variability in change over multiple years. The evaluation in 2011 included the initial and ongoing methods utilized in the Statewide PIP, which was the non-clinical PIP evaluated for each MCHP for the remeasurement year. Each MCHP was to develop individualized interventions to create improved outcomes for their members.

2.3 Performance

Table 2 – Performance Improvement Project Validation Findings by MCHP

Step	Item	MO HealthNet Managed Care Health Plans											
		BA+		CMFHP		Harmony		HCUSA		MO Care		Molina	
		Improving PCP Follow-Up After Non-Emergent ER Visits	Improving Oral Health	Improving Childhood Immunizations	Improving Oral Health	Improving Asthma Management	Improving Oral Health	Decreasing Non-Emergent/Avoidable ED Utilization	Improving Oral Health	Decreasing Emergency Department Utilization	Improving Oral Health	Reducing Repeat Emergency Department Visits for Members with Asthma	Improving Oral Health
Step 1: Selected Study Topics	1.1	2	2	2	2	2	2	2	2	2	2	2	2
	1.2	2	2	2	2	2	2	2	2	2	2	2	2
	1.3	2	2	2	2	2	2	2	2	2	2	2	2
Step 2: Study Questions	2.1	2	2	2	2	2	2	2	2	2	2	2	2
Step 3: Study Indicators	3.1	2	2	2	1	2	2	2	2	2	2	1	2
	3.2	2	2	2	1	2	2	2	2	2	2	2	2
Step 4: Study Populations	4.1	2	2	2	2	2	2	2	2	1	2	2	2
	4.2	2	2	2	2	2	2	2	2	1	2	2	2
Step 5: Sampling Methods	5.1	NA	NA	NA	NA	2	2	NA	NA	NA	NA	2	NA
	5.2	NA	NA	NA	NA	NA	2	NA	NA	NA	NA	2	NA
	5.3	NA	NA	NA	NA	NA	2	NA	NA	NA	NA	0	NA
Step 6: Data Collection Procedures	6.1	2	2	2	1	2	2	2	2	2	2	1	2
	6.2	2	2	2	2	2	1	2	2	2	2	1	2
	6.3	2	2	2	2	2	2	2	2	2	1	1	2
	6.4	2	2	2	1	2	2	2	2	2	2	1	2
	6.5	2	2	2	1	1	2	2	2	2	2	0	2
	6.6	2	2	2	2	2	2	2	2	2	2	1	2
Step 7: Improvement Strategies	7.1	2	2	2	1	1	2	2	2	1	2	1	0
Step 8: Analysis and Interpretation of Study Results	8.1	2	2	2	1	1	1	2	2	1	2	0	2
	8.2	2	2	2	1	1	2	2	2	1	2	1	2
	8.3	2	2	NA	1	1	2	2	2	1	2	1	2
	8.4	2	2	NA	1	2	NA	2	2	1	2	1	2
Step 9: Validity of Improvement	9.1	2	2	NA	0	NA	NA	2	2	NA	2	NA	1
	9.2	2	2	NA	0	NA	NA	2	2	NA	2	NA	1
	9.3	2	2	NA	1	NA	NA	2	2	NA	2	NA	0
	9.4	2	2	NA	2	NA	NA	2	2	NA	2	NA	1
Step 10: Sustained Improvement	10	2	2	NA	1	NA	NA	NA	2	NA	NA	NA	1
Number Met		24	24	17	10	15	19	23	24	12	22	9	18
Number Partially Met		0	0	0	12	5	2	0	0	7	1	10	4
Number Not Met		0	0	0	2	0	0	0	0	0	0	3	2
Number Applicable		24	24	17	24	20	21	23	24	19	23	22	26
Rate Met		100.0%	100.0%	100.0%	41.7%	75.0%	90.5%	100.0%	100.0%	63.2%	95.7%	40.9%	69.2%

Note: 0 = Not Met; 1 = Partially Met; 2 = Met

2.4 Findings

Below are the PIPs identified for validation at each MCHP:

BA+	Improving PCP Follow-Up After Non-Emergent ER Visits Improving Oral Health
Children' Mercy Family Health Partners	Improving Childhood Immunizations Improving Oral Health
Harmony Health Plan of Missouri	Improving Asthma Management Improving Oral Health
HealthCare USA	Decreasing Non-Emergent/Avoidable Emergency Department Utilization Improving Oral Health
Missouri Care	Decreasing Emergency Department Utilization Improving Oral Health
Molina Health Care of Missouri	Reducing Repeat Emergency Department Visits for Members with Asthma Improving Oral Health

STEP 1: SELECTED STUDY TOPICS

Study topics were selected through data collection and the analysis of comprehensive aspects of member needs, care, and services; and to address a broad spectrum of key aspects of member care and services. In all cases they included all enrolled populations pertinent to the study topic without excluding certain members. Two of the clinical PIPs addressed care of members with asthma; three addressed avoiding non-emergent use of emergency departments; and one PIP focused on improving the number of children receiving their immunizations. All six non-clinical projects addressed improving oral health through MCHP specific interventions, as extensions of the Statewide PIP.

Table 2 shows the ratings for each item and PIP by MCHP. All twelve (12) PIPs provided a rationale demonstrating the extent of the need for the PIP and provided information to support selection of the study topic. All Study Topic presentations employed a literature or research review that

supported the planned performance improvement activities. This research provided some benchmark comparison data. This section met the study methodology criteria required 100% of the time. All of the MCHPs addressed a broad spectrum of key aspects of member care and services (100.0%). Each MCHP submitted one clinical and one non-clinical intervention for review. An array of the aspects of enrollee care and services were included in these studies.

Utilization or cost issues may be examined through a PIP, but are not to be the sole focus of any study. There were descriptions of the member populations targeted for intervention in the PIPs. Because the MCHPs vary widely in the member populations they serve (e.g., other state Medicaid managed care members, commercial members, or Medicare members), and in some cases serve markets both in Missouri and elsewhere, they are asked to develop their projects for this specific market. During 2011, the PIPs submitted reflected projects that focused on the Missouri MO HealthNet population. In addition, PIPs should specifically indicate whether all enrolled populations within the MO HealthNet Managed Care Program are included in the interventions. Finally, age and demographic characteristics should be described. All twelve PIPs (100.00%) “Met” these criteria (Step 1.3).

STEP 2: STUDY QUESTIONS

Study questions are statements in the form of a question that describe the potential relationship between the intervention, the intended outcome, and the data to be obtained and analyzed. They should be specific enough to suggest the study methods and the outcome measures. The MCHPs made a concerted effort to ensure that statements were provided in the form of a question, and the questions were directly related to the hypotheses and topic selected. Twelve (100.00%) of the PIPs included clearly stated study questions (Step 2.1). The study purposes identified were consistent with the remainder of the PIP (the target population, interventions, measures, or methods) in the studies presented.

Table 3 - Summary of Performance Improvement Project Validation Ratings by Item, All MCHPs

Step	All MCHPs					
	Item	Number Met	Number Partially Met	Number Not Met	Total Number Applicable	Rate Met
Step 1: Selected Study Topics	1.1	12	0	0	12	100.00%
	1.2	12	0	0	12	100.00%
	1.3	12	0	0	12	100.00%
Step 2: Study Questions	2.1	12	0	0	12	100.00%
Step 3: Study Indicators	3.1	10	2	0	12	83.33%
	3.2	11	1	0	12	91.67%
Step 4: Study Populations	4.1	11	1	0	12	91.67%
	4.2	11	1	0	12	91.67%
	4.3	11	1	0	12	91.67%
Step 5: Sampling Methods	5.1	3	0	0	3	100.00%
	5.2	2	0	0	2	100.00%
	5.3	1	0	1	2	50.00%
Step 6: Data Collection Procedures	6.1	10	2	0	12	83.33%
	6.2	10	2	0	12	83.33%
	6.3	10	2	0	12	83.33%
	6.4	10	2	0	12	83.33%
	6.5	9	2	1	12	75.00%
	6.6	11	1	0	12	91.67%
Step 7: Improvement Strategies	7.1	7	4	1	12	58.33%
Step 8: Analysis and Interpretation of Study Results	8.1	7	4	1	12	58.33%
	8.2	8	4	0	12	66.67%
	8.3	7	4	0	11	77.78%
	8.4	7	3	0	10	70.00%
Step 9: Validity of Improvement	9.1	5	1	1	7	71.43%
	9.2	5	1	1	7	71.43%
	9.3	5	1	1	7	71.43%
	9.4	6	1	0	7	85.71%
Step 10: Sustained Improvement	10.1	3	2	0	5	60.00%
Number Met		217	41	7	265	81.89%

Note: Percent Met = Number Met/Number Applicable; Item refers to the Protocol specifications.

Source: BHC, Inc., 2011 External Quality Review Performance Improvement Project Validation

STEP 3: STUDY INDICATORS

In the past several reviews most MCHPs produced PIPs that “Met” the criteria for defining and describing the calculation of study indicators. In 2011, ten (83.33%) of the PIPs met the criteria for using objective, clearly defined, measurable indicators (Step 3.1). In these PIPs the calculation of measures was described and explained. Even when well-known measures were used (e.g., Healthcare Effectiveness Data and Information Set—HEDIS), there was a detailed description of the methods (e.g., Administrative or Hybrid Method) and formulas for calculating the measures. Because MCHPs vary in their method of calculation, details regarding the measures and methods of calculating those measures should be included in PIPs. One MCHP (Molina) included three indicators for their clinical PIP. Although they defined the indicators, how they will be tracked and used to report outcomes remained unclear throughout the narrative. One MCHP (Children’s Mercy Family Health Partners) did not provide updated indicators for 2011 for their non-clinical PIP. Eleven of the 12 PIPs (91.67%) identified and detailed at least one study indicator that was related to health or functional status; or to processes of care strongly associated with outcomes. One MCHP (Children’s Mercy Family Health Partners) was considered as “Partially Met” in this area. How the indicator related to the 2011 PIP was not included. The link between the intervention and the outcomes measured by the PIP should be explicit in the narrative.

STEP 4: STUDY POPULATIONS

The MCHPs made an attempt to meet the criteria for adequately defining the study population. The evaluation examines if all members to whom the study question(s) and indicator(s) were relevant are included. Eleven MCHPs did include adequate information to make this determination (Step 4.1). One MCHP (Missouri Care) “Partially Met” this criteria for one PIP, as they did not adequately explain or define the population. Eleven of the PIPs, including those considered non-clinical, made an attempt to define the applicable study population considered. The selection criteria should clearly describe the member populations included in the PIP and their demographic characteristics. Eleven of the 12 PIPs (91.67%) described data collection approaches indicating that data for all members to whom the study question applied were collected (Step 4.2). In most cases there was a description that at least allowed inference of how data were collected and how participants were identified. One MCHP (Missouri Care) failed to define the population or provide narrative on how the study methodology would capture the population.

STEP 5: SAMPLING METHODS

Nine of these PIPs stated that they did not employ true sampling techniques. The type of sample (e.g., convenience, random) or sampling methods (e.g., simple, cluster, stratified) should be described if utilized. It should be noted that the two (2) PIPs submitted by Harmony included documentation stating that they were conducting a random sample in an effort to conduct case record reviews at provider offices. The presentation for each PIP was slightly different. Both are coded as “Met.” The description, in both cases, is discussed and when appropriate they are assessed as meeting sampling method requirements that would relate any valid or reliable data. A second MCHP (Molina) employed sampling for their clinical PIP. They employed a non-probability sample, which was explained. They did not provide enough information to determine if the sample contained a sufficient number of enrollees. The explanation included vague and conflicting information. This section (5.3) is considered “Not Met.”

STEP 6: DATA COLLECTION PROCEDURES

Ten of the 12 PIPs (88.33%) described the data to be collected with adequate detail and description of the units of measurement used (Step 6.1). Ten of the 12 (83.33%) PIPs clearly specified the sources of data (e.g., claims, members, providers, medical records) for each measure (Step 6.2). The evaluation looks for a methodology that provides a structure for reporting measures and data sources. In some instances there is more than one source of data. It is important that the MCHP specifically states the sources of data for each measure. The MCHPs generally provided adequate narrative and explanation to allow for validation of the PIP. This allows the EQRO to validate each element. Ten of the 12 PIPs (83.33%) clearly described systematic and reliable methods of data collection (Step 6.3). There was some description of the data collection procedures in all cases. It is not possible to judge the reliability or credibility of any PIP without sufficient detail regarding data collection processes, procedures, or frequency. Ten of the PIPs used a data collection instrument that was described in detail. This step requires that data be presented utilizing instruments that allowed consistent and accurate data would be collected over time (Step 6.4). Ten of the PIPs (83.33%) met this element of the required study submissions. One MCHP (Molina) did not include a complete study design in its PIP submission for its clinical PIP, so these elements could not be adequately evaluated. Three MCHPs (Harmony, Missouri Care, and Family Health Partners) failed to include enough information to allow for a complete evaluation of all of these elements of the study design and data collection procedures. They each had one element, and in one case 2 elements, that were “Partially Met.”

Nine of the PIPs (75.0%) included a complete data analysis plan, while two PIPs were rated “Partially Met” (Harmony, Children’s Mercy Family Health Partners) and one was rated as “Not Met” (Molina Health Care) for specifying a plan (Step 6.5). The prospective data analysis plan should be developed prior to the implementation of the PIP, be based on the study questions, should explain the anticipated relationship between the intervention(s) and outcome(s) being measured (i.e. independent and dependent variables); include the method(s) of data collection; and the nature of the data (e.g., nominal, ordinal, scale). One MCHP (Molina) did not address this requirement in their clinical PIP.

Eleven of the 12 (91.67%) PIPs identified the project leader and qualifications of that individual in the narrative submitted. They identified who was involved in or provided oversight for the design, implementation, data analysis, and interpretation of the PIP (Step 6.6). MCHP staff interviewed on-site also included team members who were involved and knowledgeable about the PIPs and methods. One PIP (Molina Health Care), only gave the name of the project leader for the clinical PIP. No information was provided about this individual’s qualification or role and responsibilities regarding the project.

STEP 7: IMPROVEMENT STRATEGIES

Seven of the 12 (58.33%) PIPs included reasonable interventions to address the barriers identified through data analysis and the quality improvement processes undertaken. Four of the PIPs were “Partially Met” in this requirement. One of the PIPs submitted by Molina was coded as “Not Met”. The nature of identification of the barriers, a description of barriers, and a plan for addressing barriers should be described. In all cases the interventions should be presented clearly. Narrative must be available that explains how the interventions are related to the goals of the study, how they are expected to impact the study outcomes, and why they were specifically chosen to address the barrier or problems defined.

STEP 8: DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

All twelve PIPs included at least a partial data analysis. In seven PIPs (58.33%) the analyses was conducted according to the data analysis plan (Step 8.1). Three MCHPs (Harmony – both PIPs, Missouri Care, and CMFHP) only partially met this requirement. One MCHP (Molina) was rated as “Not Met.” In eight of the PIPs (66.67%) there was a complete and thorough analysis of the data presented. These eight PIPs presented baseline and re-measurement data if it was available. All numerical findings were provided accurately and clearly (Step 8.2). In some instances, data were

presented in formats different from those described in the calculation of measures (e.g., presenting percentages in graphic format while the description of the calculation of measures indicated rates per 1,000). Axis labels and units of measurement should be reported in Tables, and in Figure legends. This information should be clearly identifiable to the reader. Tables should be part of the body of the PIP and include a narrative explanation of the results.

Seven of eleven PIPs presented at least one re-measurement period (77.78%) that included data for all of the measures identified in the study (Step 8.3). Seven of the ten PIPs described were mature enough to present findings (70.00%) that described an effective intervention (8.4). Four MCHPs (Molina, Harmony, Missouri Care, and Family Health Partners) each presented one PIP with an analysis that was not updated for 2011, not clear and understandable, or that did not relate their findings to the interventions.

STEP 9: VALIDITY OF IMPROVEMENT

Five of the seven PIPs (71.43%) with re-measurement points used the same method at re-measurement as used in the baseline measurement (Step 9.1). Whenever possible the baseline measure should be recalculated consistently with the re-measurement method to ensure validity of reported improvement and comparability of the measurement over time. The same source of data used in the baseline measure should be used at each re-measurement point. One MCHP (Molina) was rated as “Partially Met.” The narrative explained their intentions and gave preliminary information. No updates or complete information was provided. One MCHP (Children’s Mercy Family Health Partners) was rated as “Not Met.” No information was provided for 2011.

Five of the seven (71.43%) PIPs that were mature enough to include data analysis employed statistical significance testing to document quantitative improvements in care (Step 9.2). They were able to show improvement over the re-measurement points available. This improvement was not always statistically significant. Five of seven (71.43%) PIPs reporting improvements had face validity, meaning that the reported improvement was judged as related to the intervention applied (Step 9.3). These PIPs provided some discussion or interpretation of findings in the narrative. Additional narrative in this area would ensure proper evaluation of all data and information provided. After reporting findings, some interpretation as to whether the intervention, or other factors, accounted for the noted improvement, decline, or lack of change. Six of the seven (85.71%) PIPs reached a level of maturity to include this data, and provided statistical evidence that the observed

improvement was true improvement (Step 9.4). Barriers should be identified and addressed for the next cycle of the PIP, or reasons for discontinuing the PIP should be described.

STEP 10: SUSTAINED IMPROVEMENT

Five of the PIPs were able to make an assessment regarding sustained improvement. Three of the five (60.00%) were able to demonstrate repeated measurements over time that created confidence in the sustainability of the improvements achieved. These PIPs used statistical significance testing to demonstrate improvement. The PIPs reaching this level of maturity provided arguments for continuing the improvement efforts leading to success, and their reasoning for maintained sustainability. All six MCHPs stated that they would be incorporating the processes developed during the PIP into the routine operations when they achieve positive results.

2.5 Conclusions

Across all MCHPs the range in proportion of criteria that were "Met" for each PIP validated was 40.90% through 100%. Across all PIPs validated statewide, 81.89% of criteria were met. All sources of available data were used to develop the ratings for the PIP items. The EQRO comments were developed based on the written documentation and presentation of findings. In most of the cases, there was enough information provided to validate the PIPs. On-site interviews and subsequent information revealed in-depth knowledge of the PIPs and detailed outcomes for five of the MCHPs. One MCHP (Molina) did not allow the on-site review to occur, resulting in no staff interviews, clarification of information submitted, or updates to results.

Generally the PIPs presented included thoughtful and complex information. In some of the PIPs, enhanced information obtained at the on-site review, made it clear that the MCHPs intended to use this process to improve organizational functions and the quality of services available or delivered to members. In at least five cases the performance improvement project had already been incorporated into MCHP daily operations. PIPs are to be ongoing, with periodic re-measurement points. At least quarterly re-measurement is recommended to provide timely feedback to the MCHP regarding the need to address barriers to implementation. MCHP personnel involved in PIPs had experience in clinical service delivery, quality improvement, and monitoring activities. It was clear in at least nine of the PIPs that the MCHP had made a significant investment in designing valid

evaluation studies using sound data collection and analysis methods. This requires technical expertise in health services research and/or program evaluation design.

Based on the PIP validation process, all of the MCHPs had active and ongoing PIPs as part of their quality improvement programs. One MCHP (Harmony) made significant improvement in using the PIP process to enhance the quality of organizational performance.

An improved commitment to the quality improvement process was observed during the on-site review at the five MCHPs where this review was possible.

Table 4 - Validity and Reliability of Performance Improvement Project Results

PIP Name	Rating
Improving PCP Follow-Up After Non-Emergent ER Visits (BA+)	High Confidence
Improving Oral Health (BA+)	Moderate Confidence
Improving Childhood Immunizations (CMFHP)	Moderate Confidence
Improving Oral Health (CMFHP)	Moderate Confidence
Improving Asthma Management (Harmony)	Low Confidence
Improving Oral Health (Harmony)	Low Confidence
Increased Use of Controller Medication for Members with Persistent Asthma (HCUSA)	High Confidence
Improving Oral Health (HCUSA)	High Confidence
Decreasing Emergency Department Utilization (MO Care)	Moderate Confidence
Improving Oral Health (MO Care)	Moderate Confidence
Reducing Repeat Emergency Department Visits for Members with Asthma (Molina)	Low Confidence
Improving Oral Health (Molina)	Moderate Confidence

Note: Not Credible = There is little evidence that the study will or did produce results that could be attributed to the intervention(s); Low Confidence = Few aspects of the PIP were described or performed in a manner that would produce some confidence that findings could be attributed to the intervention(s); Moderate Confidence = Many aspects of the PIP were described or performed in a manner that would produce some confidence that findings could be attributed to the intervention(s); High Confidence = The PIP study was conducted or planned in a methodologically sound manner, with internal and external validity, standard measurement, and data collection practices, and appropriate analyses to calculate that there is a high level of confidence that improvements were a result of the intervention. A 95% to 99% level of confidence in the findings was or may be able to be demonstrated.

Source: BHC, Inc., 2011 External Quality Review Performance Improvement Project Validation.

The following summarizes the quality, access, and timeliness of care assessed during this review, and provides recommendations based on the findings of the Validation of Performance Improvement Projects activity.

ACCESS TO CARE

Access to care was an important theme addressed throughout most of the PIP submissions reviewed. A major goal of the statewide non-clinical PIP is improved access to dental care. This goal was reflected in the individual PIP projects developed by each MCHP. Access to care was also an important focus in the clinical PIPs. Four MCHPs focused on assisting and educating members in developing PCP and specialist relationships in an effort to avoid the unnecessary use of the emergency department. These PIPs had a significant focus on providing access to the correct medical provider through a variety of interventions. All the projects reviewed used the format of the PIP to improve access to care for members. Two projects focused on ensuring that members had adequate and timely access to asthma management services and childhood immunizations with the goal of providing access to primary and preventive care. The on-site discussions with MCHP staff indicated that they realize that improving access to care is an ongoing aspect of all projects that are developed.

QUALITY OF CARE

Topic identification was an area that provided evidence of the attention paid to providing quality services to members. Intervention development for PIPs also focused on the issue of quality services. The PIPs reviewed focused on topics that needed improvement, either in the internal processes used to operate the MCHP, or in the direct provision of services delivered. The corresponding interventions that addressed barriers to quality care and health outcomes were clearly evident in the narratives submitted, as well as in the discussions with MCHPs during the on-site review. These interventions addressed key aspects of enrollee care and services, such as medication and treatment management; risk identification; use of additional case management and in-home service; monitoring provider access and quality services; and preventive care. These efforts exemplified an attention to quality healthcare services.

TIMELINESS OF CARE

Timeliness of care was a major focus of a number of the PIPs reviewed. The four projects addressing inappropriate use of the emergency department attempted to address the need for timely and appropriate care for members to ensure that services are provided in the best environment in a timely manner (Molina, Healthcare USA, BA Plus, and Missouri Care). Other projects focused on the subjects of timely utilization of preventive care such as improved access to childhood immunizations (Children's Mercy Family Health Partners) and managing members with asthma (Harmony). The need for timely access to preventive and primary health care services was recognized an essential component of these projects. The MCHPs all related their awareness of the need to provide not only quality, but timely services to members. Projects reflected this awareness, as they addressed internal processes and direct service improvement. The PIPs related to improving Annual Dental Visits included a focus on obtaining timely screenings and recognized that this is an essential component of effective preventive care.

RECOMMENDATIONS

1. It is recommended that MCHPs continue to refine their skills in the development and implementation of the Performance Improvement Projects. Improved training, assistance and expertise for the design, statistical analysis, and interpretation of PIP findings are available. Ensuring that a variety of topics are recognized each year and that more than one PIP is in process is essential.
2. PIPs should be conducted on an ongoing basis, with at least quarterly measurement of some indices to provide data about the need for changes in implementation, data collection, or interventions. Ongoing PIPs should include new and refined interventions. Next steps should be included in the narrative and planning for all on-going PIPs. On-going PIPs should include necessary data and narrative.
3. Efforts to continue to improve outcomes related to the Statewide PIP topic should be continued. Several MCHPs provided results indicating improvement in their HEDIS measure. A number of innovative approaches were used to impact this issue. The MCHPs should continue with their individualized interventions and their individual approaches to obtaining positive outcomes when working on a statewide topic. They should not assume that their recognized improvement means the PIP is no longer in process.

4. It appears that most of the MCHPs conduct PIPs on an ongoing basis as part of their quality improvement program. Continuing to utilize these PIPs as tools to improve the organizations ability to serve members is recommended.

3.0 VALIDATION OF PERFORMANCE MEASURES

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3.1 Purpose and Objectives

The EQRO is required by the Validating Performance Measures Protocol to evaluate three performance measures reported by each MCHP. These measures are selected by the State Medicaid Agency each year (SMA; the Missouri Department of Social Services, MO HealthNet Division; MHD). For the HEDIS 2011 evaluation period, the three performance measures selected for validation were Annual Dental Visits (ADV), Childhood Immunizations Status, Combination 3 (CIS3), and Follow-Up After Hospitalization for Mental Illness (FUH). The Annual Dental Visits measure was reviewed in the HEDIS 2010, 2009, 2008, and HEDIS 2007 evaluation periods. The Follow-Up After Hospitalization for Mental Illness measure was also reviewed in 2010, 2009, 2007, and 2006. The Childhood Immunizations Status measure has not previously been reviewed for Combination 3; the CIS Combination 2 was reviewed in HEDIS 2005. Protocol activities performed by the EQRO for this audit included: 1) Review of the processes used by the MCHPs to analyze data; 2) Evaluation of algorithmic compliance with performance measure specifications; and 3) Recalculation of either the entire set of performance measure data (administrative rates) or a subset of the data (hybrid rates) to verify and confirm the rates reported by the MCHPs are based upon accurate calculations.

The objectives for validating performance measures were to: 1) evaluate the accuracy of Medicaid performance measures reported by, or on behalf of the MCHPs; and 2) determine the extent to which MCHP-specific performance measures calculated by the MCHPs (or by entities acting on behalf of the MCHPs) followed specifications established by the SMA and the State Public Health Agency (SPHA; Missouri Department of Health and Senior Services; DHSS) for the calculation of the performance measure(s).

3.2 Findings

The method of calculation used by each MCHP is detailed in Table 5; this information was taken from the MCHPs' self-report to the EQRO.

Table 5 - Summary of Method of Calculation Reported and Validated by MCHPs

MO HealthNet MCHP	Annual Dental Visit	Childhood Immunizations Status, Combo 3	Follow-Up After Hospitalization for Mental Illness
Blue-Advantage Plus	Administrative	Hybrid	Administrative
Children's Mercy Family Health Partners	Administrative	Hybrid	Administrative
Harmony	Administrative	Hybrid	Administrative
Healthcare USA	Administrative	Hybrid	Administrative
Missouri Care	Administrative	Hybrid	Administrative
Molina Healthcare	Administrative	Hybrid	Administrative

The validation of each of the performance measures is discussed in the following sections with the findings from each validation activity described. Subsequent sections summarize the status of submission of the measures validated to the SMA and SPHA, the Final Audit Ratings, and conclusions.

HEDIS 2011 ANNUAL DENTAL VISIT

Data Integration and Control

The objective of this activity was to assess the MCHPs' ability to link data from multiple sources. It is based on the integrity of the management information systems and the ability to ensure accuracy of the measures. For the HEDIS 2011 Annual Dental Visit measure, the sources of data included enrollment, eligibility, and claim files. The rate of items that were met was calculated across MCHPs and from the number of applicable items for each MCHP. Five of the six MCHPs that calculated the measure met all criteria for every audit element.

However, one MCHP was rated as Not Met in the category of data integration and control, as this MCHP did not participate in the on-site review as required by the CMS Validating Performance Measures protocol. All other MCHPs were 100% compliant with the criteria for data integration and control.

Documentation of Data and Processes

The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling numerators and denominators; and the ability to apply proper algorithms. Five of the six MCHPs met the applicable criteria for applying appropriate data and processes for the calculation of the HEDIS 2011 Annual Dental Visit measure. One MCHP refused to allow the EQRO onsite for a review and therefore does not meet the criteria for Documentation of Data and Processes.

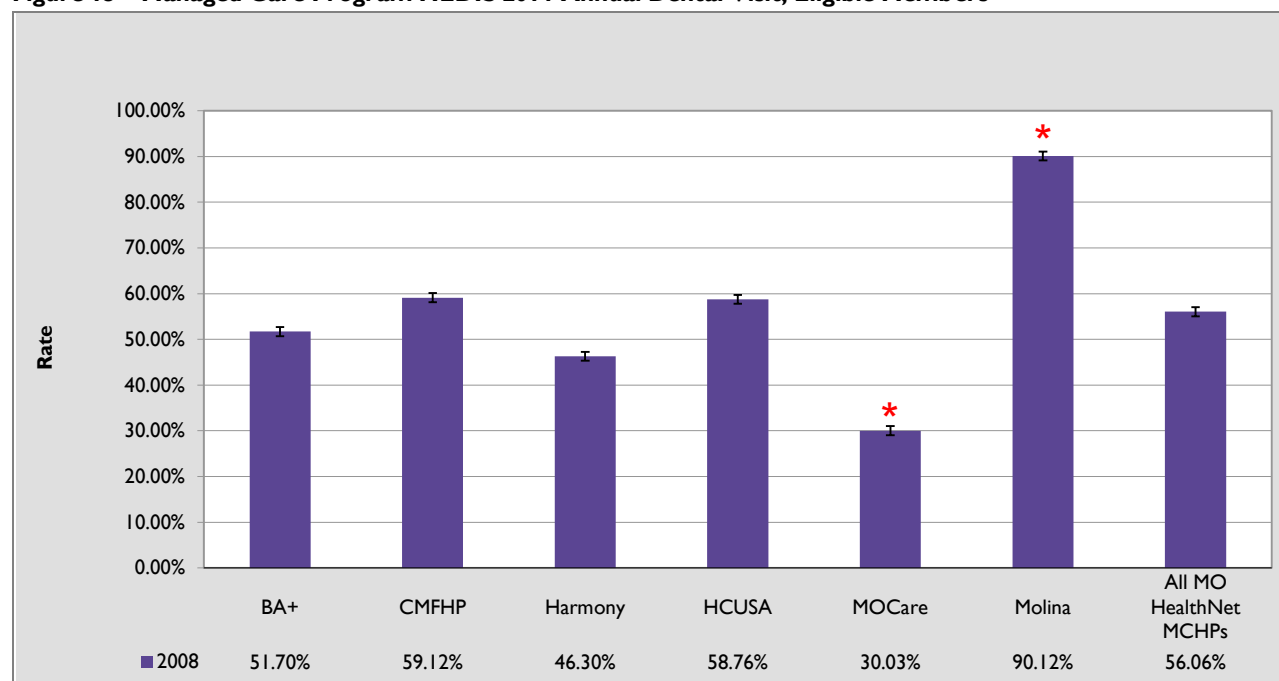
Processes Used to Produce Denominators

The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for calculating each measure. Five of the six MCHPs reviewed met 100% of the applicable criteria for producing denominators according to specifications. However, one MCHP was rated as Not Met in the category of Processes Used to Produce Denominators, as this MCHP did not participate in the on-site review as required by the CMS Validating Performance Measures protocol, and therefore the EQRO was unable to assess that MCHP's information system in person, as required. All other MCHPs were 100% compliant with the criteria for data integration and control.

When determining the denominator, it was expected that all MCHPs would identify similar percentages of their total population as eligible for this measure. The identification of eligible members for the HEDIS 2011 Annual Dental Visit measure is dependent on the quality of the enrollment and eligibility files. The rate of eligible members (eligible population identified / total enrollment) was calculated for all MCHPs and is illustrated in Figure 15. Two-tailed z-tests of

each MCHP were conducted comparing the MCHPs to the rate of eligible members for all MCHPs at the 95% level of confidence. Assuming that Molina Healthcare’s information system was validated, the percentage of eligible members identified by Molina Healthcare (90.12%) showed a statistically **higher** rate when compared to the group average. Missouri Care showed statistically **lower** rate (30.03%) than the MCHP average. These differences in rates may be due to the demographic characteristics of the member population, the completeness of claims data, or the processes of identifying eligible members.

Figure 15 – Managed Care Program HEDIS 2011 Annual Dental Visit, Eligible Members



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance. Enrollment as of the last week in December 2010 (the measurement year) was used to calculate the rate.

Sources: MCHP HEDIS 2011 Data Submission Tool (DST); Missouri Department of Social Services, MO HealthNet Division, State MPRI Session Screens, enrollment figures for all Waivers, December 31, 2010.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MCHPs' ability to accurately identify medical events, evaluate the ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. The Technical Specifications for the HEDIS 2011 Annual Dental Visit measure required the measure be calculated using the Administrative Method; the Hybrid Method procedures do not apply. Table 6 shows the numerators, denominators, and rates submitted by the MCHPs to the SPHA on the DST for the HEDIS 2011 Annual Dental Visit measure. It is the task of the EQRO to compare MCHP to MCHP on a statewide level. Therefore, for all MCHPs who reported rates by region (e.g. HCUSA and Molina), the regional numbers were combined to create a plan-wide rate.

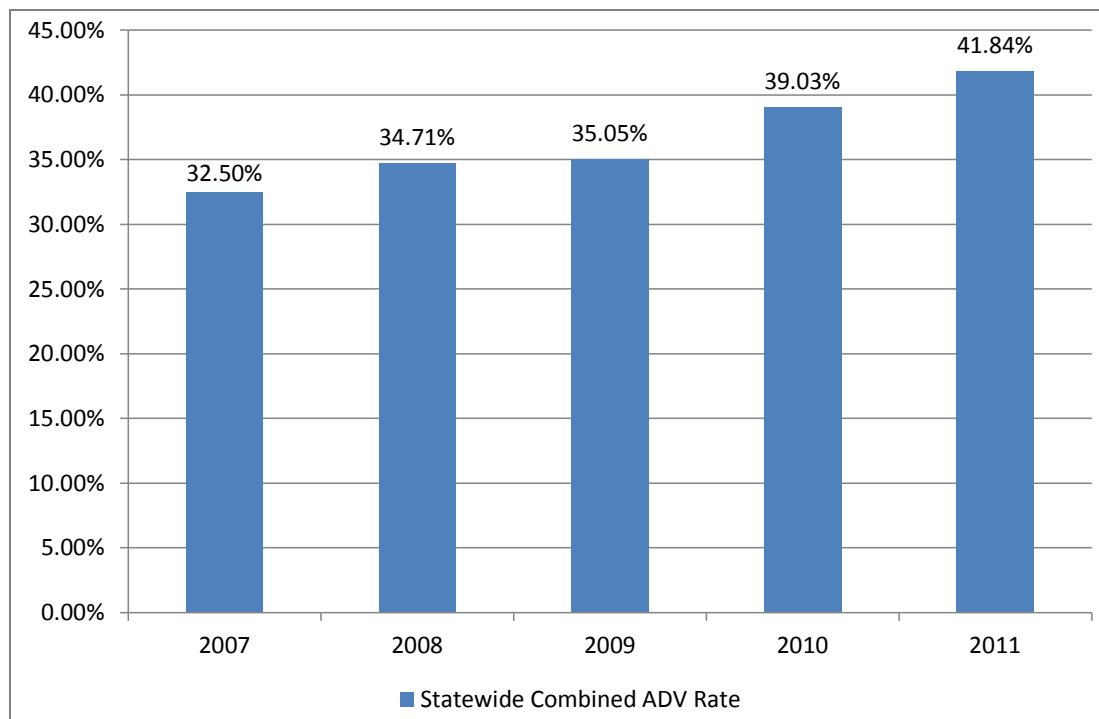
Table 6 - Data Submission and Final Validation for HEDIS 2011 Annual Dental Visit (combined rate)

Managed Care Health Plan	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Blue-Advantage Plus	15,956	6,529	40.92%	6,521	40.87%	0.05%
Childrens Mercy Family Health Partners	33,072	15,788	47.74%	15,778	47.71%	0.03%
Harmony Health Plan	7,569	2,153	28.44%	2,150	28.41%	0.04%
HealthCare USA	114,335	49,283	43.10%	49,201	43.03%	0.07%
Missouri Care	24,371	10,075	41.34%	10,058	41.27%	0.07%
Molina Healthcare	45,230	16,816	37.18%	16,801	37.15%	0.03%
All MCHPs	240,533	100,644	41.84%	100,509	41.79%	0.06%

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. Rate Validated by EQRO = Administrative Hits Validated by EQRO / Eligible Population. Estimated Bias = Rate Reported by MCHP (DST) - Rate Validated by EQRO. Positive bias indicates an overestimate.

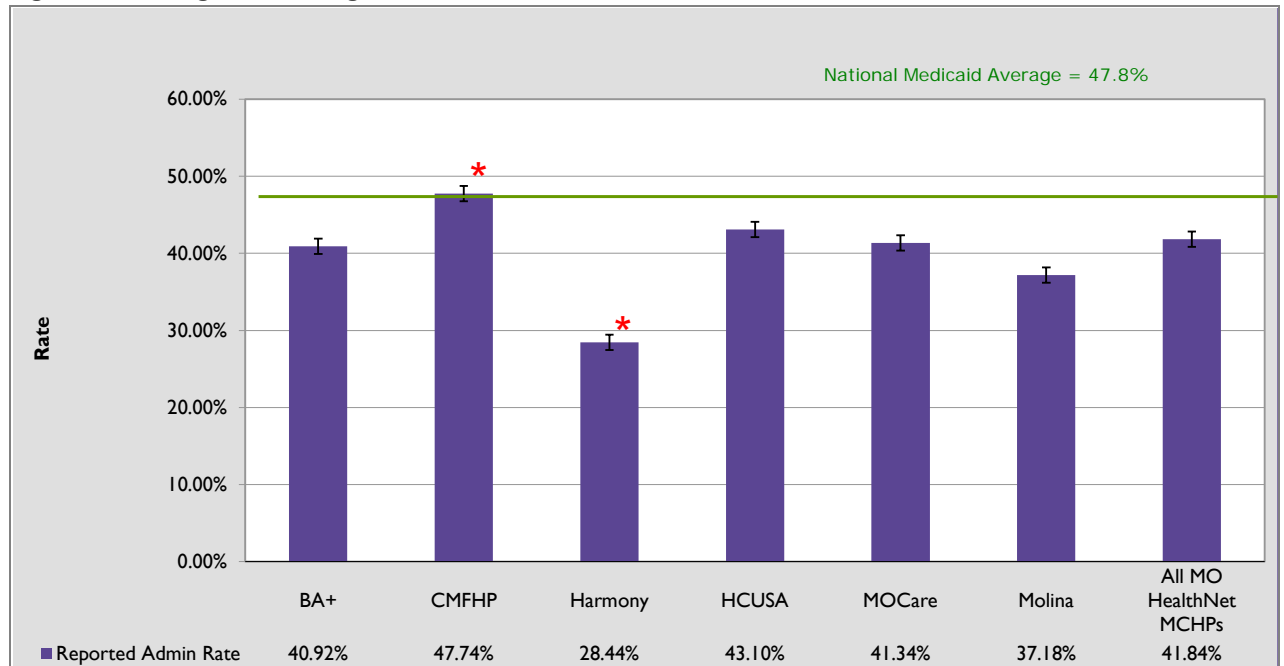
Source: MCHPs' HEDIS 2011 Data Submission Tools (DST).

Figure 16 –Managed Care Program Statewide Rate Comparison for HEDIS Measure: Annual Dental Visit



The Annual Dental Visit measure has been reviewed for the last five audit years: 2007, 2008, 2009, 2010, and 2011 (see Figure 16). In all five of these audits, the MCHPs reported individual rates lower than the National Medicaid Average. The combined rates for all plans were also lower than this average. However, the National Medicaid Average has increased over time, as has the combined rate for all MCHPs. The 2011 MCHP rates ranged from 28.44% (Harmony) to 47.74% (CMFHP; see Table 6 and Figure 17). Harmony reported a significantly lower rate than the average combined rate for all MCHPs; the rate reported by CMFHP was significantly **higher** than the average. The rates for all MCHPs were 32.50%, 34.71%, 35.05%, 39.03%, and 41.84% in 2007, 2008, 2009, 2010, and 2011 respectively. This indicates an increase in access to dental visits over time within the MO HealthNet Managed Care population.

Figure 17 - Managed Care Program HEDIS 2011 Annual Dental Visit, Administrative Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance.

Sources: MCHP HEDIS 2011 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

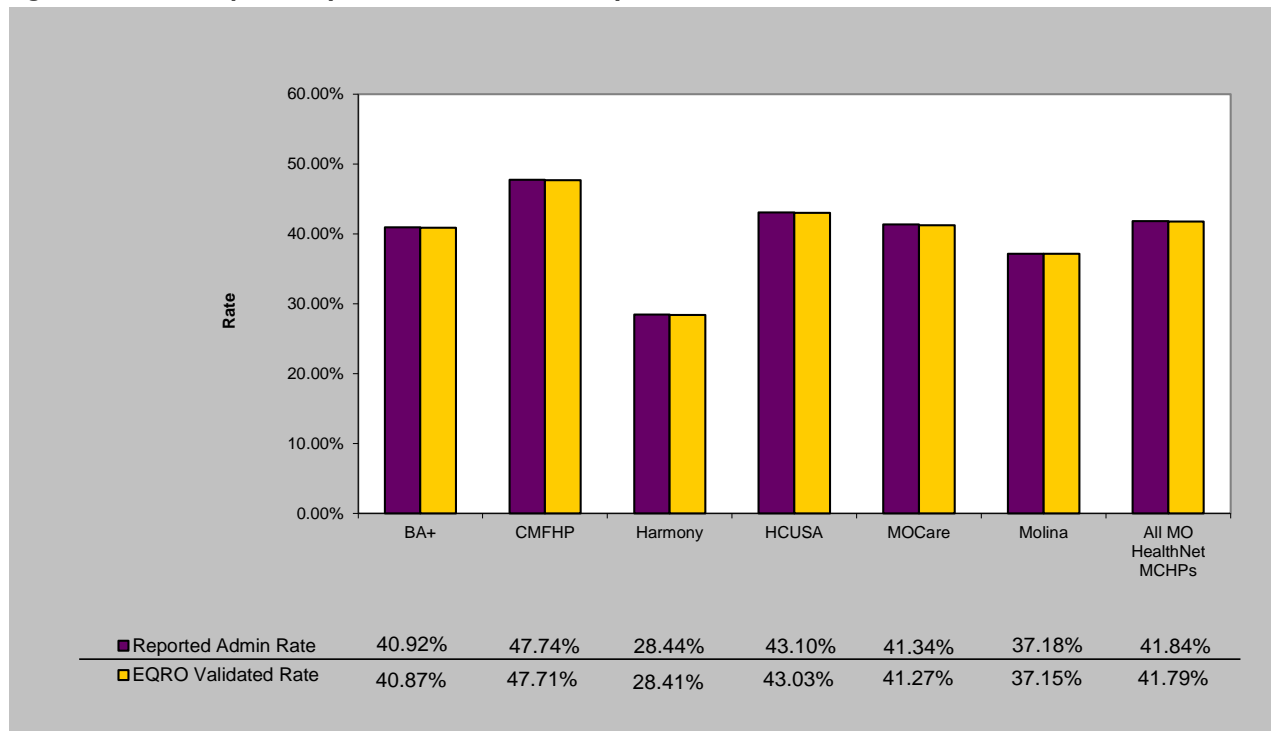
Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2011 Annual Dental Visit measure. All six MCHPs calculated and submitted the measure to the SPHA and SMA. All MCHPs in the State of Missouri are required to calculate and report the measure to the SPHA, and MCHPs are required to report the measure to the SMA.

Final Validation Findings

Table 6 on page 76 shows the final data validation findings and the total estimated bias calculation based on the validation and review of the MCHPs' extract files for calculating the HEDIS 2011 Annual Dental Visit measure. Figure 18 illustrates the differences between the rates reported to the SPHA and those calculated by the EQRO for Annual Dental Visit calculations. The EQRO validated rate was 41.79%, while the rate reported by MCHPs was 41.84%, a 0.06% overestimate.

Figure 18 - Rates Reported by MCHPs and Validated by EQRO, HEDIS 2011 Annual Dental Visit Measure



Sources: MCHP HEDIS 2011 Data Submission Tool (DST); BHC, Inc. 2011 External Quality Review Performance Measure Validation.

HEDIS 2011 CHILDHOOD IMMUNIZATIONS STATUS, COMBINATION 3

Data Integration and Control

The objective of this activity was to assess the MCHPs' ability to link data from multiple sources for the calculation of the HEDIS 2011 Childhood Immunizations Status measure, specifically for Combination 3. It is related to the integrity of the management information systems and the ability to ensure accuracy of the measures. For the HEDIS 2011 Childhood Immunizations Status Combo 3 measure, the sources of data included enrollment, eligibility, and claim files. The rate of items that were Met was calculated across MCHPs and from the number of applicable items for each MCHP. No data integration and control issues were discovered by the EQRO. Five of the six MCHPs (83.3%) met the criteria for all areas of data integration and control. However, one MCHP was rated as Not Met in the category of data integration and control, as this MCHP did not participate in the on-site review as required by the CMS Validating Performance Measures protocol. All other MCHPs were 100% compliant with the criteria for data integration and control.

Documentation of Data and Processes

The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling, numerators and denominators; and the ability to apply proper algorithms for the calculation of HEDIS 2011 Childhood Immunizations Status Combo 3 measure. Five of the six MCHPs calculating the measure met 100.0% of the criteria for processes used to calculate and report the HEDIS 2011 Childhood Immunizations Status Combo 3 measure. One MCHP refused to allow the EQRO onsite for a review and therefore does not meet the criteria for Documentation of Data and Processes.

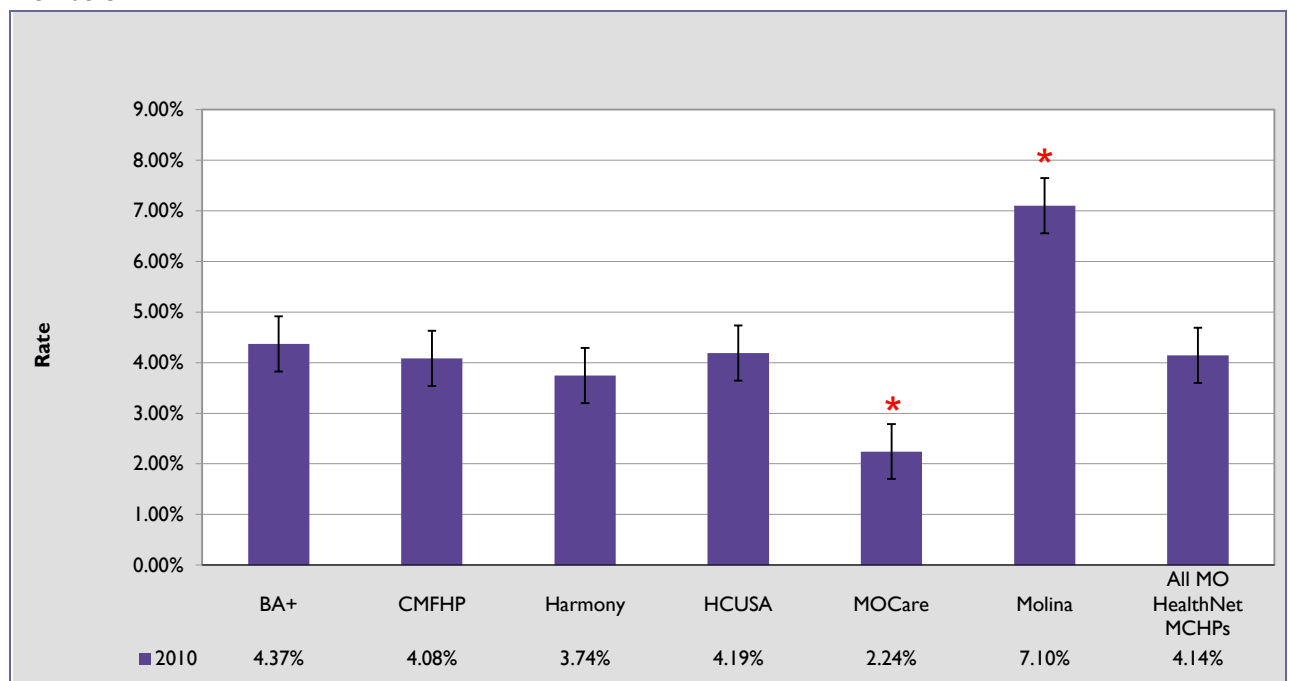
Processes Used to Produce Denominators

The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for each measure. For the HEDIS 2011 Childhood Immunizations Status Combo 3 measure, the sources of data include enrollment, eligibility, and claim files. Overall, five of the six MCHPs (83.3%) met all the criteria for the processes used to produce denominators. However, one MCHP was rated as Not Met in the category of Processes Used to Produce Denominators, as this MCHP did not participate in the on-site review as required by the CMS Validating Performance Measures protocol, and therefore the EQRO was unable to assess that MCHP's information system

in person, as required. All other MCHPs were 100% compliant with the criteria for data integration and control.

Figure 19 illustrates the rate of eligible members identified by each MCHP, based on the enrollment of all Managed Care members as of December 31, 2010. It was expected that MCHPs would identify similar proportions of eligible members for the HEDIS 2011 Childhood Immunizations Status Combo 3 measure. The rate of eligible members (percent of eligible members divided by the total enrollment) was calculated for all MCHPs and two-tailed z-tests of each MCHP compared to the state rate of eligible members were conducted at the 95% level of confidence. Missouri Care (2.24%) identified a rate that was significantly lower than the MCHP average (4.14%). Assuming that Molina Healthcare's information system was valid, the percentage of eligible members identified by Molina (7.10%) was significantly **higher** than the Managed Care average.

Figure 19 - Managed Care Program HEDIS 2011 Childhood Immunizations Status Combo 3, Eligible Members



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance. Enrollment as of the last week in December 2010 (the measurement year) was used to calculate the rate.

Sources: MCHP HEDIS 2011 Data Submission Tool (DST); Missouri Department of Social Services, MO HealthNet Division, State MPRI Session Screens, enrollment figures for all Waivers, December 31, 2010.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MCHPs' ability to accurately identify medical events, evaluate the ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. For the HEDIS 2011 Childhood Immunizations Status Combo 3 measure, the sources of data included enrollment, eligibility, and claim files. Table 7 shows the numerators, denominators, and rates submitted by the MCHPs to the SPHA on the DST. The "combined" rates for HCUSA and Molina were calculated by the EQRO based on reported rates for each region (Central, Eastern, and Western). The rate for all MCHPs was 57.47%, with MCHP rates ranging from 47.93% (Harmony) to 64.14 % (MO Care).

Table 7 - Data Submission for HEDIS 2011 Childhood Immunizations Status Combo 3 Measure

MO HealthNet MCHP	Final Data Collection Method Used	Denominator (DST)	Administrative Hits Reported by MCHP (DST)	Hybrid Hits Reported by MCHP (DST)	Total Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)
Blue Advantage Plus	Hybrid	411	212	46	258	62.77%
Childrens Mercy Family Health Partners	Hybrid	411	153	70	223	54.26%
Harmony Health Plan	Hybrid	411	97	100	197	47.93%
HealthCare USA	Hybrid	1296	495	213	708	54.63%
Missouri Care	Hybrid	449	152	136	288	64.14%
Molina Healthcare	Hybrid	1228	458	285	743	60.50%
All MO HealthNet MCHPs		4,206	1,567	850	2,417	57.47%

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. The statewide rate for all MCHPs was calculated by the EQRO using the sum of numerators divided by sum of denominators. There was no statewide rate or confidence limits reported to the SMA or SPHA.

Source: Managed Care Organization HEDIS 2011 Data Submission Tools (DST)

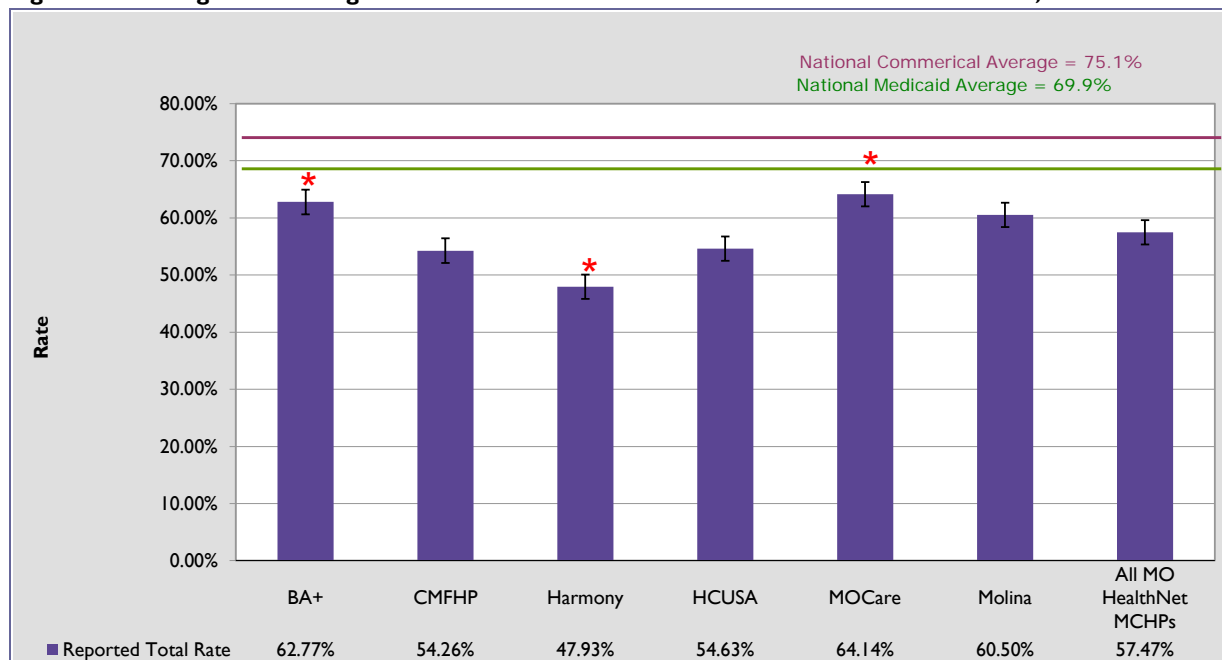
The Childhood Immunizations Status Combo 3 measure has not been audited in previous external quality reviews; the Childhood Immunizations Status Combo 2 measure was audited during the HEDIS 2005 review. Therefore, there is no applicable comparison data to report.

Figure 21 and Figure 22 illustrate the rates reported by the MCHPs and the rates of administrative and hybrid hits for each MCHP. The rate reported by each MCHP was compared with the rate for

all MCHPs. Two-tailed z-tests of each MCHP comparing each MCHP to the rate for all MCHPs were calculated at the 95% confidence interval.

The rate for all MCHPs (57.47%) was lower than both the National Medicaid rate (69.9%) and the National Commercial Rate (75.1%). The rates for BA+ (62.77%) and MO Care (64.14%) were significantly **higher** than the overall MCHP average. Harmony reported a rate of 47.93%, which was significantly lower than the statewide rate for all MCHPs.

Figure 20 - Managed Care Program HEDIS 2011 Childhood Immunizations Status Combo 3, Rates

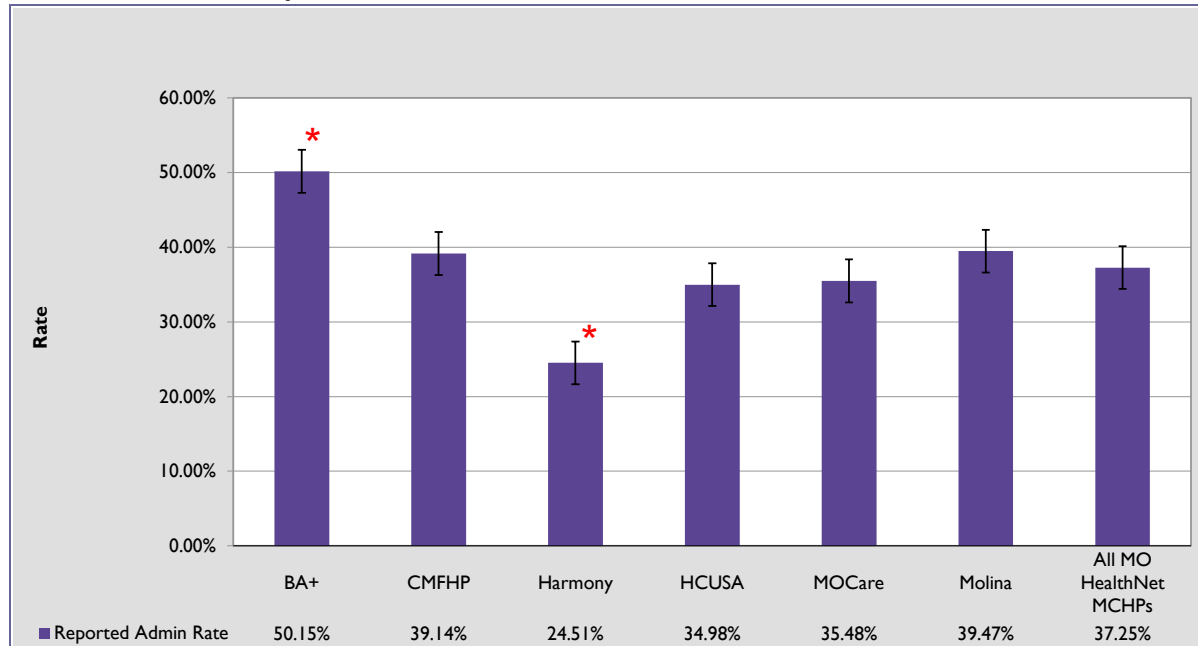


Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance.

Sources: MCHP HEDIS 2011 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

When the rate of administrative and hybrid hits was examined separately, the rates varied somewhat from the combined rate for all MCHPs (37.25%). Rates ranged from 24.51% (Harmony) to 50.15% (BA+). Statistically, the rate reported by Harmony was significantly lower than the statewide rate for all MCHPs, while the rate for BA+ was significantly **higher** than the average rate.

Figure 21 - Managed Care Program HEDIS 2011 Childhood Immunizations Status Combo 3, Administrative Rate Only

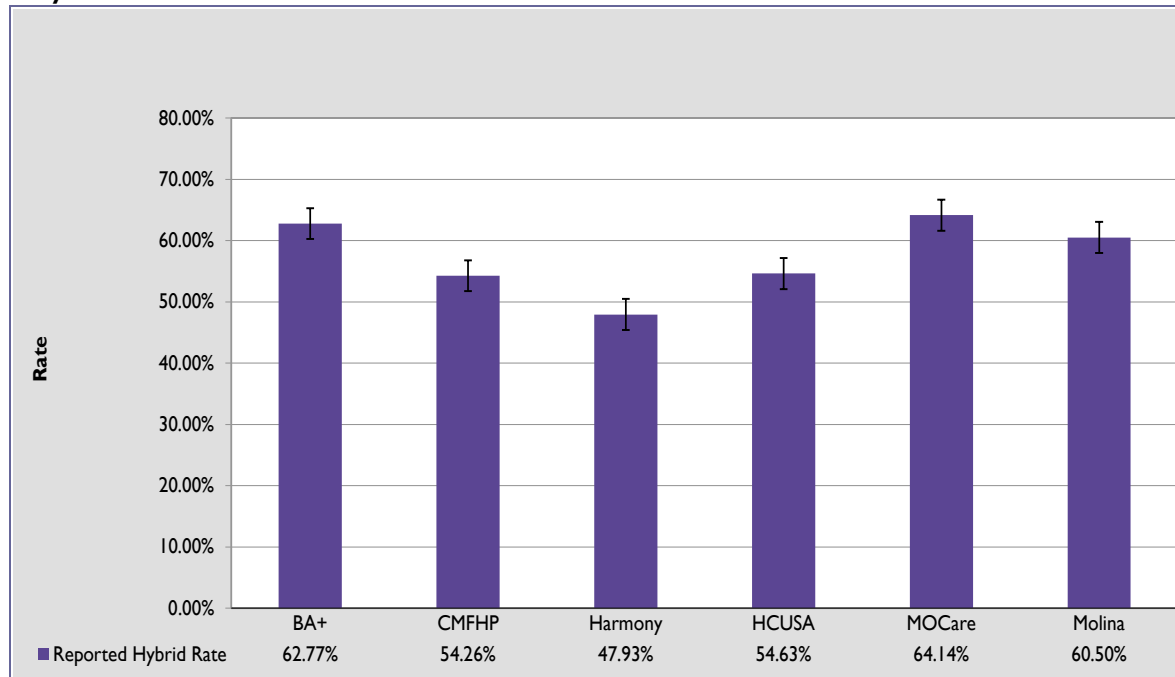


Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance.

Sources: MCHP HEDIS 2011 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Each of the six MCHPs calculated the Childhood Immunizations Status measure hybridly. There were no statistically significant differences between the average for all MCHPs found in these rates.

Figure 22 - Managed Care Program HEDIS 2011 Childhood Immunizations Status Combo 3, Hybrid Rate Only



Note: Error bars on the y-axis represent 95% confidence intervals

Sources: MCHP HEDIS 2011 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA)

Table 8 and Table 9 summarize the findings of the EQRO medical record review validation and Attachment XII (Impact of Medical Record Findings) of the CMS Protocol. All of the six MCHPs used the Hybrid Method of calculation. BA+, CMFHP, and Harmony each selected a sample of 411 eligible members, consistent with HEDIS technical specifications. MO Care selected a sample of 449 eligible members, as determined by the number of eligible members and in accordance with HEDIS technical specifications. HCUSA and Molina operate in multiple regions; therefore, the sample sizes selected for each region were combined to represent the overall MCHP rates. A total of 180 of the 850 medical record hybrid hits reported by MCHPs were sampled for validation by the EQRO. Of the records requested, all 180 were received for review. The EQRO was able to validate all 180 of the records received, resulting in an Error Rate of 0% across all MCHPs. The number of False Positive Records (the total amount that could not be validated) was 0 of the 850 reported hits. This

shows no bias in the estimation of hybrid rates for the MCHPs based upon medical record review. Table 9 shows the impact of the medical record review findings.

Table 8 - Medical Record Validation for HEDIS 2011 Childhood Immunizations Status Combo 3 Visits Measure

MCHP Name	Denominator (Sample Size)	Numerator Hits by Medical Records (DST)	Number Medical Records Sampled for Audit by EQRO	Number Medical Records Received for Audit by EQRO	Number Medical Records Validated by EQRO	Rate Validated of Records Received	Accuracy Rate	Error Rate	Weight of Each Medical Record	False Positive Records	Estimated Bias from Medical Records
BAPLus	411	46	30	30	30	100.0%	100.0%	0.0%	0.002	0	0.0%
CMFHP	411	70	30	30	30	100.0%	100.0%	0.0%	0.002	0	0.0%
Harmony	411	100	30	30	30	100.0%	100.0%	0.0%	0.002	0	0.0%
HCUSA	1296	213	30	30	30	100.0%	100.0%	0.0%	0.001	0	0.0%
MOCare	449	136	30	30	30	100.0%	100.0%	0.0%	0.002	0	0.0%
Molina	1228	285	30	30	30	100.0%	100.0%	0.0%	0.001	0	0.0%
All MCHPs	4,206	850	180	180	180	100.0%	100.0%	0.0%	0.0002	0	0.0%

Note: DST = Data Submission Tool; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); Accuracy Rate = Number of Medical Records Validated by the EQRO/Number of Records Selected for Audit by EQRO; Error Rate = 100% - Accuracy Rate; Weight of Each Medical Record = 100% / Denominator (Sample Size); False Positive Records = Error Rate * Numerator Hits Reported by MCHP (DST); Estimated Bias from Medical Records = Percent of bias due to the medical record review = False Positive Rate * Weight of Each Medical Record

Source: MCHP Data Submission Tools (DST); BHC, Inc. 2011 External Quality Review Performance Measures Validation.

Table 9 - Impact of Medical Record Findings, HEDIS 2011 Childhood Immunizations Status Combo 3 Measure

Audit Elements	MCHP Name					
	BA+	CMFHP	Harmony	HCUSA	MOCare	Molina
Final Data Collection Method Used (e.g., MRR, hybrid,)	Hybrid	Hybrid	Hybrid	Hybrid	Hybrid	Hybrid
Error Rate (Percentage of records selected for audit that were identified as not meeting numerator requirements)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Is error rate < 10%? (Yes or No)	Yes	Yes	Yes	Yes	Yes	Yes
If yes, MCHP/PIHP passes MRR validation; no further MRR calculations are necessary.	Passes	Passes	Passes	Passes	Passes	Passes
If no, the rest of the spreadsheet will be completed to determine the impact on the final rate.	NA	NA	NA	NA	NA	NA
Denominator (The total number of members identified for the denominator of this measure, as identified by the MCHP/PIHP)	411	411	411	1296	449	1,228
Weight of Each Medical Record (Impact of each medical record on the final overall rate; determined by dividing 100% by the denominator)	NA	NA	NA	NA	NA	NA
Total Number of MRR Numerator Positives identified by the MCHP/PIHP using MRR.	NA	NA	NA	NA	NA	NA
Expected Number of False Positives (Estimated number of medical records inappropriately counted as numerator positives)	NA	NA	NA	NA	NA	NA
Estimated Bias in Final Rate (The amount of bias caused by medical record review)	NA	NA	NA	NA	NA	NA

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MCHP; Administrative Method was used by the MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation.

Source: BHC, Inc. 2011 External Quality Review Performance Measure Validation.

Across all MCHPs, 100% of the applicable criteria for calculating numerators were met. All six (100%) of the MCHPs met the criteria for using the appropriate data to identify the at-risk population, using complete medical event codes, correctly classifying members for inclusion in the numerator, eliminating or avoiding double-counting members, and following applicable time parameters. All six of the MCHPs calculated this measure using the Hybrid method, and each met all criteria (100.0%) relating to medical record reviews and data. The MCHPs met 100% of criteria for calculating the numerator for the HEDIS 2011 Childhood Immunizations Status, Combination 3 measure.

Sampling Procedures for Hybrid Method

The objectives of this activity were to evaluate the MCHPs' ability to randomly sample from the eligible members for the measure when using the Hybrid Method of calculation. Across all MCHPs, the criteria for sampling were met 100.0% of the time. All MCHPs used the Hybrid Method of calculating the HEDIS 2011 Childhood Immunizations Status Combination 3 measure and all met 100.0% of the criteria for proper sampling.

Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2011 Childhood Immunizations Status Combination 3 measure. All MCHPs reported the measure to the SPHA and SMA.

Final Validation Findings

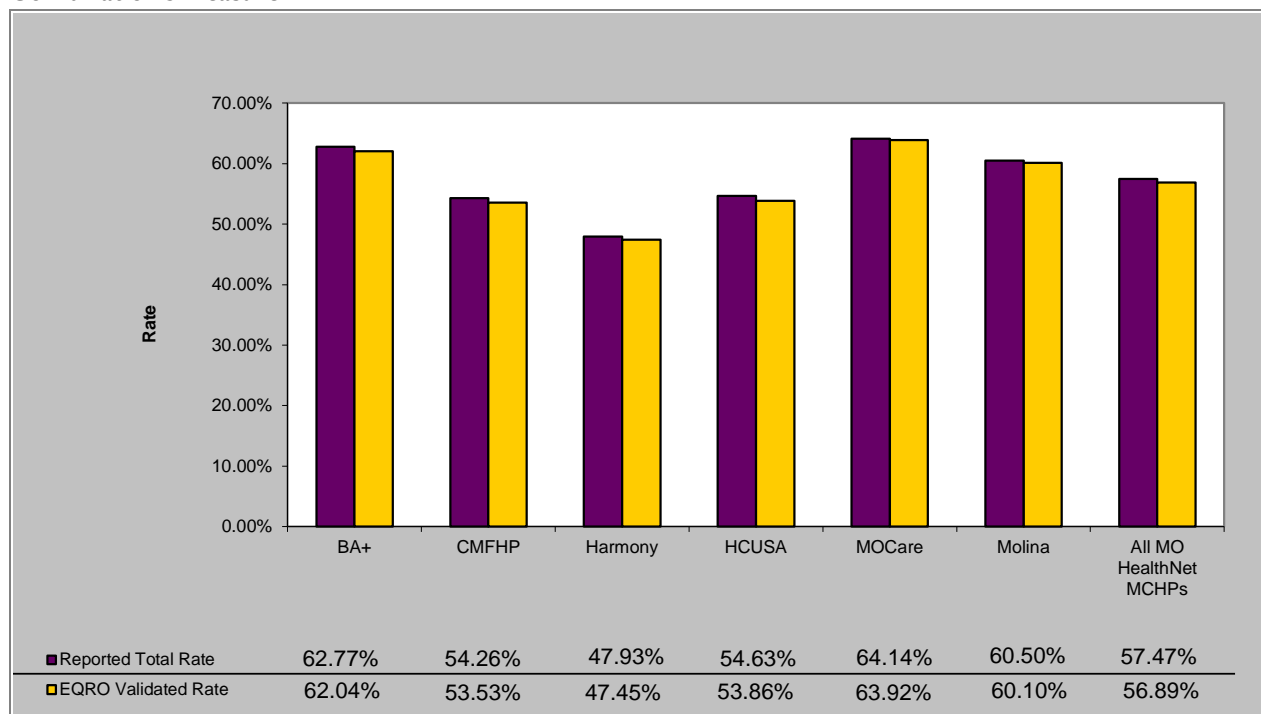
Table 10 shows the final data validation findings for the calculation of the HEDIS 2011 Childhood Immunizations Status Combination 3 measure and the total estimated bias in calculation based on the validation of medical record data and review of the MCHP extract files.

Table 10 - Final Data Validation for HEDIS 2011 Childhood Immunizations Status Combo 3 Measure

MCHP	Administrative Hits Validated by EQRO	Percentage of Medical Record Hits Validated by EQRO	Total Hits Validated by EQRO	Rate Reported by MCHP (DST)	Rate Validated by EQRO	Total Estimated Bias
BAPLus	209	100.00%	255	62.77%	62.04%	0.73%
CMFHP	150	100.00%	220	54.26%	53.53%	0.73%
Harmony	96	100.00%	196	47.93%	47.45%	0.48%
HCUSA	485	100.00%	698	54.63%	53.86%	0.77%
MOCare	152	100.00%	288	64.14%	63.92%	0.22%
Molina	453	100.00%	738	60.50%	60.10%	0.40%
All MCHPs	1545	100.00%	2395	57.47%	56.89%	0.58%

Note: NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); DST = Data Submission Tool; Administrative/Medical Record Hits Validated by EQRO = Hits the EQRO was able to reproduce from the data provided by the MCHP; Total Hits Validated by EQRO = Administrative Hits Validated by EQRO + Medical Record Hits Validated by EQRO; False Positive Records = Error Rate * Rate Reported by MCHP; Rate Validated by EQRO = Total Hits Validated by EQRO / Denominator (DST); Total Estimated Bias = Rate Reported by MCHP - Rate Validated by EQRO. Positive numbers represent an overestimate by the MCHP.

Figure 23 illustrates the differences between the rates reported to the SPHA and those calculated by the EQRO. The rate for all MCHPs calculated based on data validated by the EQRO was 56.89%, while the rate reported by all MCHPs was 57.47%, a 0.58% overestimate.

Figure 23 - Rates Reported by MCHPs and Validated by EQRO, 2011 Childhood Immunizations Status Combination 3 Measure

Sources: MCHP HEDIS 2011 Data Submission Tool (DST); BHC, Inc. 2011 External Quality Review Performance Measure Validation.

HEDIS 2011 FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Data Integration and Control

The objective of this activity was to assess the MCHPs' ability to link data from multiple sources. It is based on the integrity of the management information systems and the ability to ensure accuracy of the measures. For the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure, the sources of data included enrollment, eligibility, and claim files. The rate of items that were Met was calculated across MCHPs and from the number of applicable items for each MCHP. Five of the six MCHPs that calculated the measure met all criteria for every audit element. However, one MCHP was rated as Not Met in the category of data integration and control, as this MCHP did not participate in the on-site review as required by the CMS Validating Performance Measures protocol. All other MCHPs were 100% compliant with the criteria for data integration and control.

Documentation of Data and Processes

The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling, numerators and denominators; and the ability to apply proper algorithms.

Five of the six MCHPs met the applicable criteria for applying appropriate data and processes for the calculation of the HEDIS 2011 Annual Dental Visit measure. One MCHP refused to allow the EQRO onsite for a review and therefore does not meet the criteria for Documentation of Data and Processes.

Processes Used to Produce Denominators

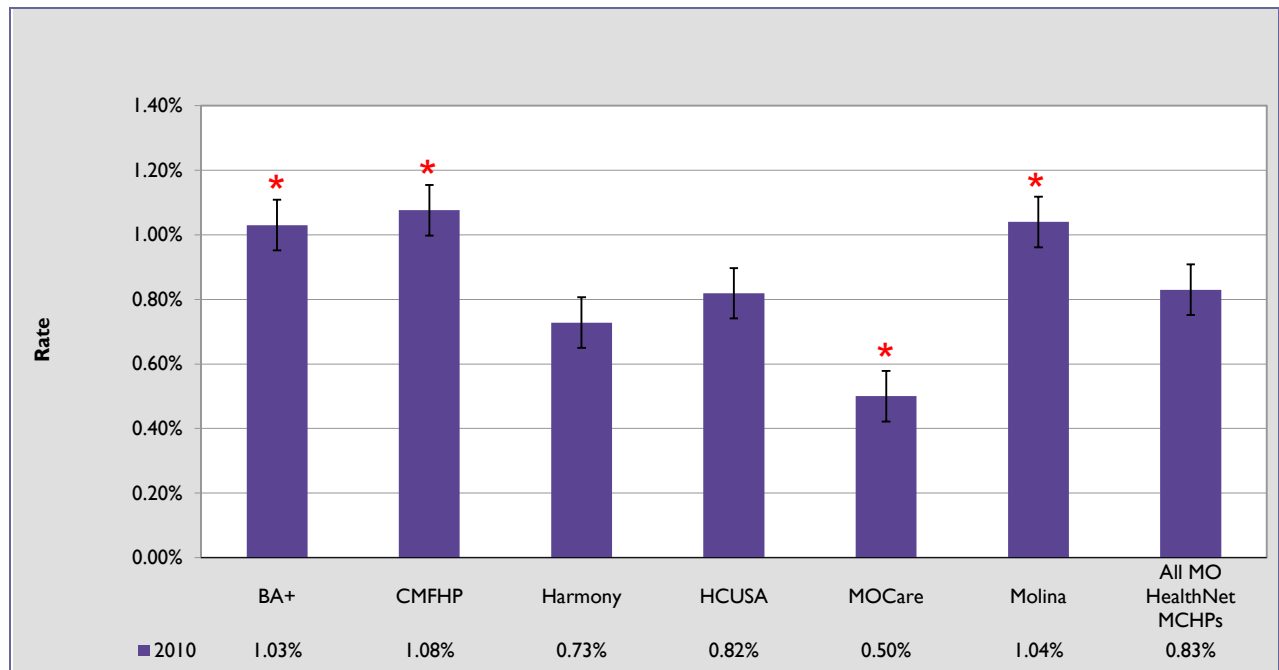
The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for each measure. For the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure, the sources of data include enrollment, eligibility, and claim files. Across all MCHPs, 100% of criteria for calculating and reporting performance measures were met.

Overall, five of the six MCHPs (83.3%) met all the criteria for the processes used to produce denominators. However, one MCHP was rated as Not Met in the category of Processes Used to Produce Denominators, as this MCHP did not participate in the on-site review as required by the CMS Validating Performance Measures protocol, and therefore the EQRO was unable to assess that MCHP's information system in person, as required. All other MCHPs were 100% compliant with the criteria for data integration and control.

Figure 24 illustrates the rate of eligible members per MCHP based on the enrollment of all Managed Care Waiver Members as of December 31, 2010. It was expected that MCHPs would identify similar proportions of eligible members for the measure. The rate of eligible members (percent of eligible members divided by the total enrollment) was calculated for all MCHPs. Two-tailed z-tests of each MCHP comparing each MCHP to the state rate of eligible members for all MCHPs were calculated at the 95% level of confidence. MO Care (0.50%) identified a significantly lower rate than the average. BA+ (1.03%), CMFHP (1.08%), and Molina (1.04%) identified significantly higher percentages. (Assuming that Molina Healthcare's information system was validated).

This variability could be due to differences in the composition of the MCHP's populations.

Figure 24 - Managed Care Program HEDIS 2011 Follow-Up After Hospitalization for Mental Illness, Eligible Members



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance. Enrollment as of the last week in December 2010 (the measurement year) was used to calculate the rate.

Sources: MCHP HEDIS 2011 Data Submission Tool (DST); Missouri Department of Social Services, MO HealthNet Division, State MPRI Session Screens, enrollment figures for all Waivers, December 31, 2010.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MCHPs' ability to accurately identify medical events, evaluate the ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. For the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure, the procedures for the Hybrid Method did not apply, as HEDIS 2011 technical specifications allow only for the use of the Administrative Method of calculating the measure.

Table 11 and Table 12 show the numerators, denominators, rates, and confidence intervals submitted by the MCHPs to the SPHA on the DST for the Follow-Up After Hospitalization for Mental Illness measure. HCUSA and Molina reported regional rates (Eastern, Central, and Western); the EQRO combined these rates to calculate a plan-wide combined rate.

Table 11 - Data Submission and Final Data Validation for HEDIS 2011 Follow-Up After Hospitalization for Mental Illness Measure (7 days)

Managed Care Health Plan	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Blue-Advantage Plus	318	166	52.20%	165	51.89%	0.31%
Childrens Mercy Family Health Partners	602	291	48.34%	289	48.01%	0.33%
Harmony Health Plan	119	47	39.50%	45	37.82%	1.68%
HealthCare USA	1,594	801	50.25%	801	50.25%	0.00%
Missouri Care	406	156	38.42%	156	38.42%	0.00%
Molina Healthcare	522	163	31.23%	163	31.23%	0.00%
All MCHPs	3,561	1,624	45.61%	1,619	45.46%	0.14%

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. Rate Validated by EQRO = Administrative Hits Validated by EQRO / Eligible Population. Estimated Bias = Rate Reported by MCHP (DST) - Rate Validated by EQRO. Positive bias indicates an overestimate.

Source: Managed Care Organization HEDIS 2011 Data Submission Tools (DST).

Table 12 - Data Submission and Final Data Validation for HEDIS 2011 Follow-Up After Hospitalization for Mental Illness Measure (30 days)

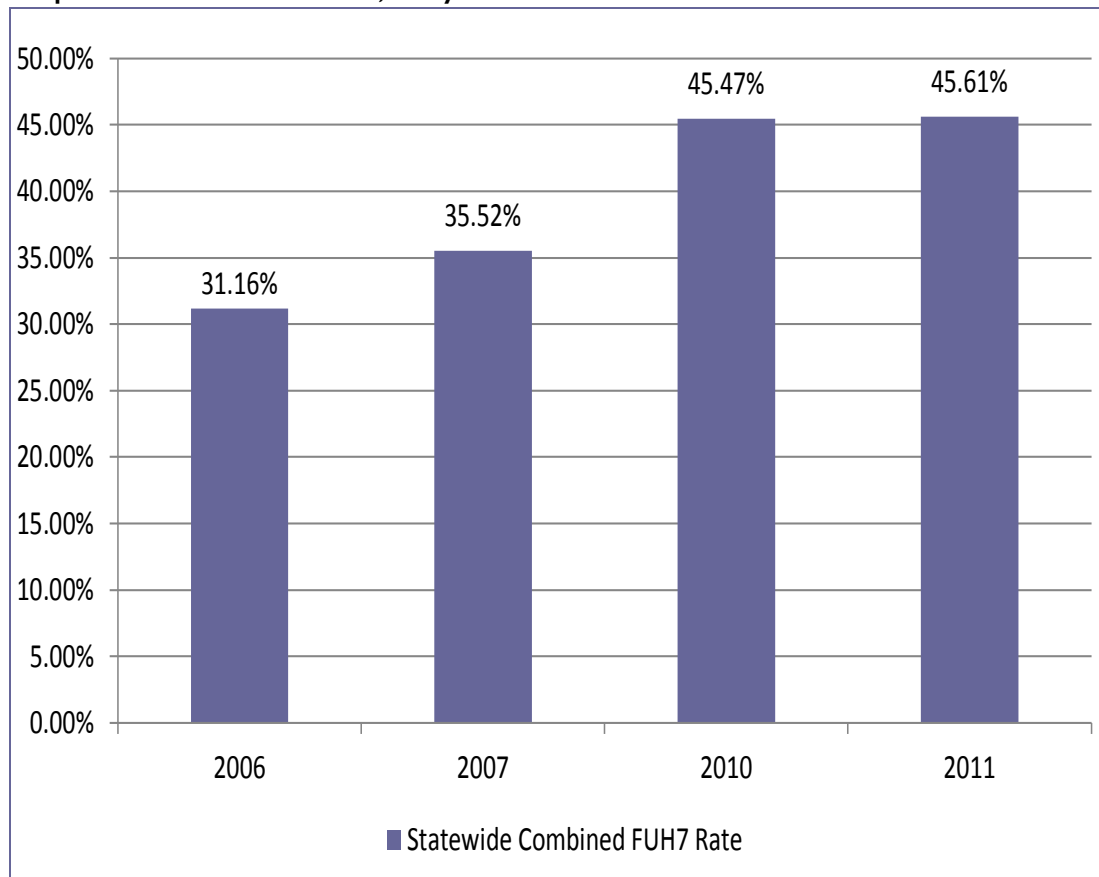
Managed Care Health Plan	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Blue-Advantage Plus	318	235	73.90%	232	72.96%	0.94%
Childrens Mercy Family Health Partners	602	430	71.43%	430	71.43%	0.00%
Harmony Health Plan	119	70	58.82%	69	57.98%	0.84%
HealthCare USA	1,594	1,134	71.14%	1,134	71.14%	0.00%
Missouri Care	406	252	62.07%	252	62.07%	0.00%
Molina Healthcare	522	237	45.40%	235	45.02%	0.38%
All MCHPs	3,561	2,358	66.22%	2,352	66.05%	0.17%

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. Rate Validated by EQRO = Administrative Hits Validated by EQRO / Eligible Population. Estimated Bias = Rate Reported by MCHP (DST) - Rate Validated by EQRO. Positive bias indicates an overestimate.

Source: Managed Care Organization HEDIS 2011 Data Submission Tools (DST).

This measure was previously audited by the EQRO in audit years 2006, 2007, 2009, and 2010. The 7-Day reported rate for all MCHPs in 2011 (45.61%) was a 14.45% increase overall since the rate reported in 2006 (31.16%); however, it is only a 0.14% increase over rate reported in 2010 (45.47 %).

Figure 25 –Managed Care Program Statewide Rate Comparison for HEDIS Measure: Follow-Up After Hospitalization for Mental Illness, 7-Day Rate



The Follow-Up After Hospitalization measure was previously audited by the EQRO in audit years 2006, 2007, 2009, and 2010 (see Figure 26). The 30-Day reported rate for all MCHPs in 2011 (66.22%) was a 13.3% increase overall since the rate reported in 2006 (52.92%), but was slightly lower than the rates reported in 2010 (69.50%) and 2009 (66.46%).

Figure 26 –Managed Care Program Statewide Rate Comparison for HEDIS Measure: Follow-Up After Hospitalization for Mental Illness 30-Day Rate

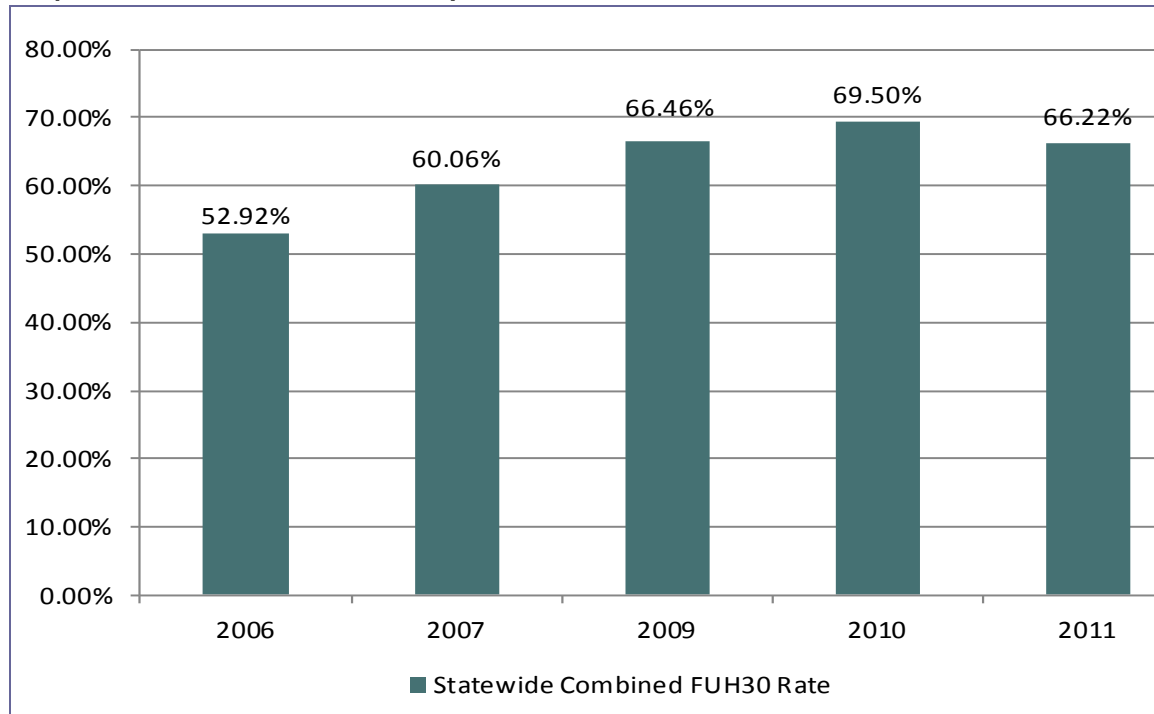
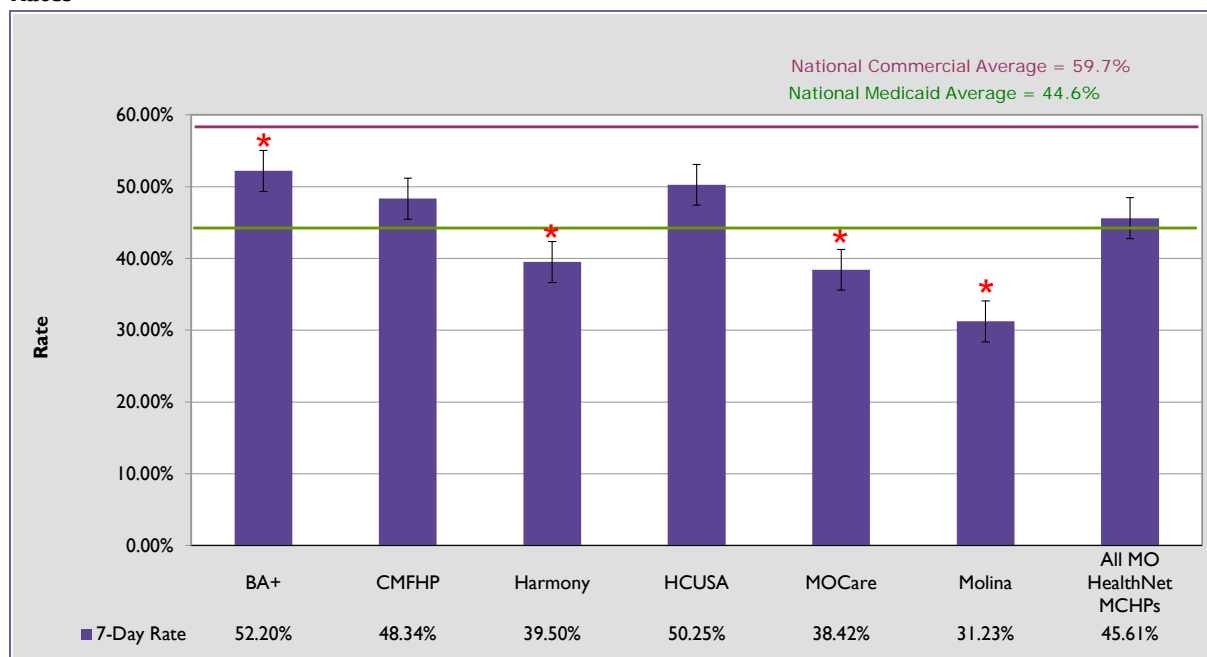


Figure 27 and Figure 28 illustrate the 7-Day and 30-Day rates reported by the MCHPs. The rate reported by each MCHP was compared with the rate for all MCHPs, with two-tailed z-tests conducted at the 95% confidence interval to compare each MCHP with the rate for all MCHPs.

The 7-Day rates reported by Harmony (39.50%), MOCare (38.42%), and Molina (31.23%) were significantly lower than the statewide rate (45.61%) for all MCHPs. BA+ reported a rate (52.20%) significantly **higher** than the average. BA+, CMFHP, and HCUSA all reported rates **higher** than the National Medicaid Rate (44.6%), although all MCHPs were below the National Commercial Rate (59.7%).

Figure 27 - Managed Care Program HEDIS 2010 Follow-Up After Hospitalization for Mental Illness, 7-Day Rates

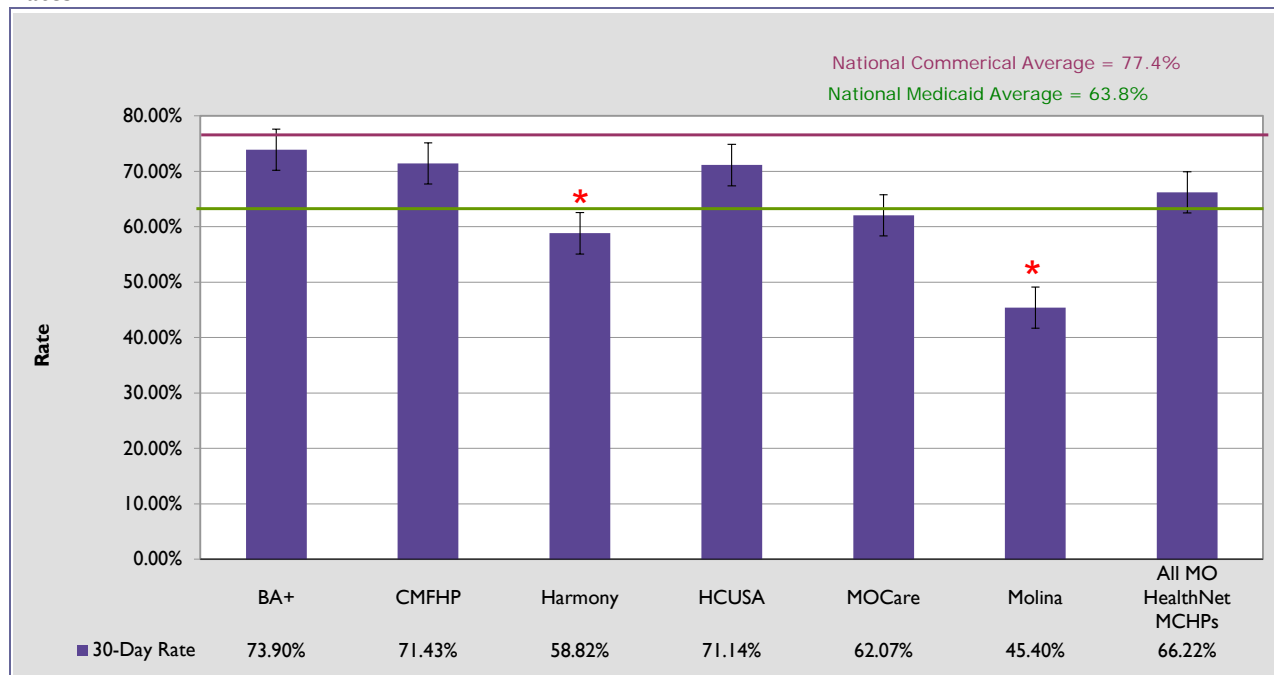


Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance.

Sources: MCHP HEDIS 2011 DST; National Committee for Quality Assurance (NCQA).

The 30-Day rates reported for Harmony and Molina (58.82% and 45.40% respectively) were significantly lower than the statewide rate (66.22%) for all MCHPs. Although all MCHPs reported rates lower than the National Commercial Average (77.4%), BA+, CMFHP, and HCUSA reported rates above the National Medicaid Rate of 63.8%.

Figure 28 - Managed Care Program HEDIS 2011 Follow-Up After Hospitalization for Mental Illness, 30-Day Rates



Note: Error bars on the y-axis represent 95% confidence intervals.

Sources: MCHP HEDIS 2011 DST; National Committee for Quality Assurance (NCQA)

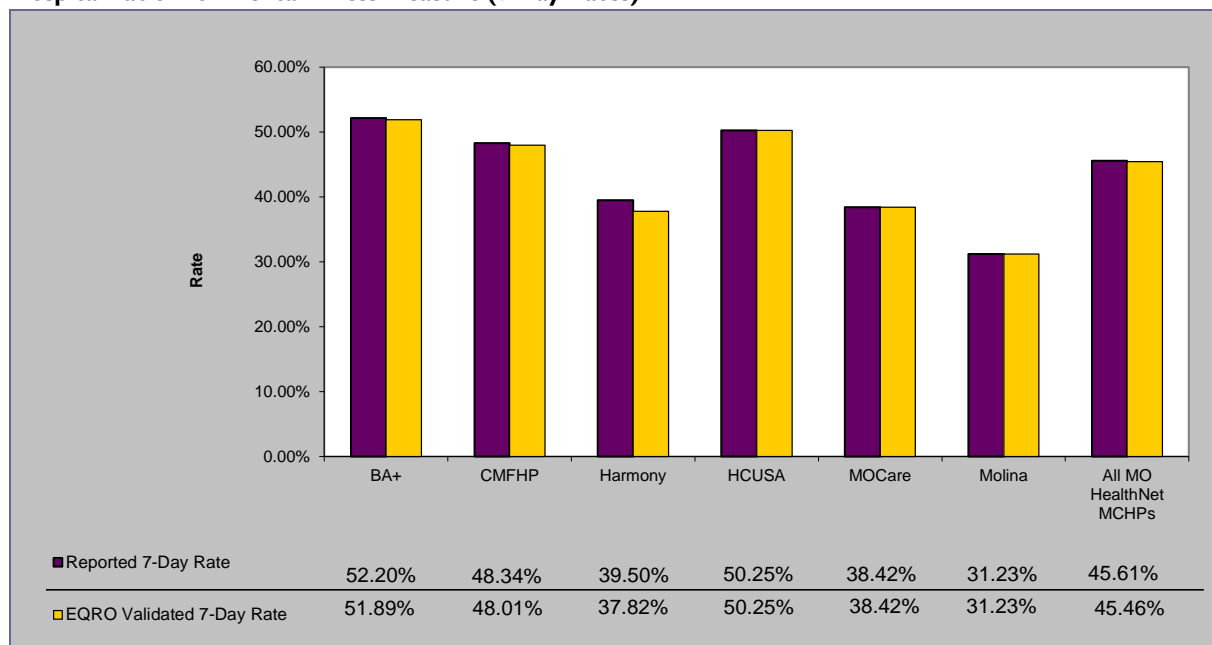
Across all MCHPs, 100% of the criteria for calculating numerators were met. Each of the MCHPs met 100.0% of criteria for the calculation of the numerator.

Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness Measure. All MCHPs calculated and submitted the measure to the SPHA and SMA.

The 7-Day rates reported by MCHPs ranged from 31.23% (Molina) to 52.20% (BA+). The rate of all MCHPs calculated based on data validated by the EQRO was 45.46%. The MCHPs reported an overall rate of 45.61%, a 0.15% overestimate (see Figure 29).

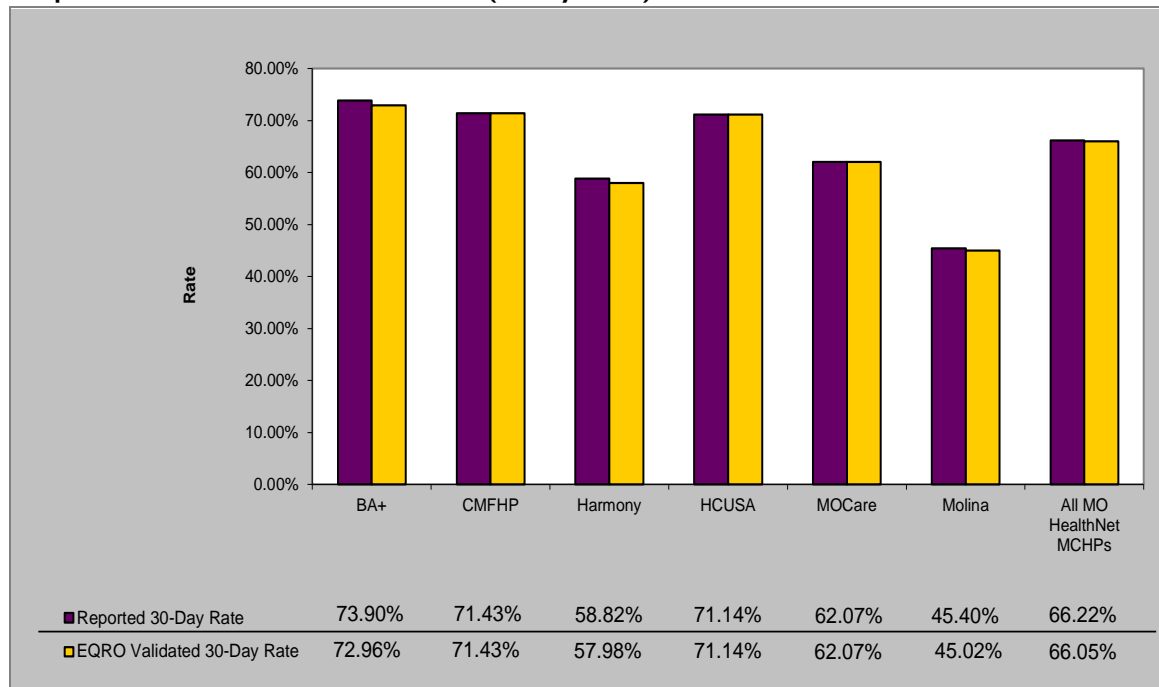
Figure 29 - Rates Reported by MCHPs and Validated by EQRO, HEDIS 2011 Follow-Up After Hospitalization for Mental Illness Measure (7-Day Rates)



Sources: MCHP HEDIS 2011 Data Submission Tool (DST); BHC, Inc. 2011 External Quality Review Performance Measure Validation.

The 30-Day rate reported by MCHPs ranged from 45.40% (Molina) to 73.90% (BA+). The rate of all MCHPs calculated based on data validated by the EQRO was 66.05%. The rate reported by MCHPs was 66.22%, a 0.17% overestimate (see Figure 30).

Figure 30 - Rates Reported by MCHPs and Validated by EQRO, HEDIS 2011 Follow-Up After Hospitalization for Mental Illness Measure (30-Day Rates)



Sources: MCHP HEDIS 2011 Data Submission Tool (DST); BHC, Inc. 2011 External Quality Review Performance Measure Validation.

Final Validation Findings

Table 13, Table 14, and Table 15 provide summaries of ratings across all Protocol Attachments for each MCHP and measure validated. The rate of compliance with the calculation of each of the three performance measures across all MCHPs was 97.78% for Annual Dental Visits; 98.61% for Childhood Immunizations Combo 3; and 97.70% for Follow-Up After Hospitalization for Mental Illness.

Table 13 - Summary of Attachment Ratings, HEDIS 2011 Annual Dental Visit Measure

All MCHPs							
All Audit Elements	BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	All MCHPs
Number Met	30	30	30	30	30	26	176
Number Partially Met	0	0	0	0	0	0	0
Number Not Met	0	0	0	0	0	4	4
Number Applicable	30	30	30	30	30	30	180
Rate Met	100%	100%	100%	100%	100%	86.67%	97.78%

Note: Rate Met = Number Met / Number Applicable. Source: BHC, Inc. 2011 EQR Performance Measure Validation

Table 14 - Summary of Attachment Ratings, HEDIS 2011 Childhood Immunizations Status Measure

All MCHPs							
All Audit Elements	BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	All MCHPs
Number Met	48	48	48	48	48	44	284
Number Partially Met	0	0	0	0	0	0	0
Number Not Met	0	0	0	0	0	4	0
Number Applicable	48	48	48	48	48	48	288
Rate Met	100%	100%	100%	100%	100%	91.67%	98.61%

Note: Rate Met = Number Met / Number Applicable. Source: BHC, Inc. 2011 EQR Performance Measure Validation

Table 15 - Summary of Attachment Ratings, HEDIS 2011 Follow-Up After Hospitalization for Mental Illness Measure

All MCHPs							
All Audit Elements	BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	All MCHPs
Number Met	29	29	29	29	29	25	170
Number Partially Met	0	0	0	0	0	0	0
Number Not Met	0	0	0	0	0	4	4
Number Applicable	29	29	29	29	29	29	174
Rate Met	100%	100%	100%	100%	100%	86.21%	97.70%

Note: Rate Met = Number Met / Number Applicable. Source: BHC, Inc. 2011 EQR Performance Measure Validation

Table 16 summarizes the final audit ratings for each of the performance measures and MCHPs. The final audit findings for each of the measures was based on the evaluation of processes for calculating and reporting the measures, medical record review validation findings, and MCHP extract files from repositories. The ratings were based on the impact of medical record review findings and the degree of overestimation of the rate as validated by the EQRO. The calculation of measures was considered invalid if the specifications were not properly followed, if the rate could not be properly validated by the EQRO due to missing or improper data, or if the rate validated by the EQRO fell outside the confidence intervals for the measure reported by the MCHPs on the DST.

Table 16 - Summary of EQRO Final Audit Ratings, HEDIS 2010 Performance Measures

MCHP	Annual Dental Visit	Childhood Immunization Status Combo 3	Follow-Up After Hospitalization for Mental Illness (7 day)	Follow-Up After Hospitalization for Mental Illness (30 day)
Blue-Advantage Plus	Substantially Compliant	Substantially Compliant	Substantially Compliant	Substantially Compliant
Children's Mercy Family Health Partners	Substantially Compliant	Substantially Compliant	Substantially Compliant	Fully Compliant
Harmony Health Plan of Missouri	Substantially Compliant	Substantially Compliant	Substantially Compliant	Substantially Compliant
Healthcare USA	Substantially Compliant	Substantially Compliant	Fully Compliant	Fully Compliant
Missouri Care	Substantially Compliant	Substantially Compliant	Fully Compliant	Fully Compliant
Molina Healthcare of Missouri	Not Valid	Not Valid	Not Valid	Not Valid

CMFHP reported rates for the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness 30-day measure that were able to be fully validated by the EQRO, garnering a rating of Fully Compliant. Both the 7-day and 30-day Follow-Up After Hospitalization for Mental Illness rates for Healthcare USA and MOCare were found to be Fully Compliant. Although all other ratings were not fully validated, the majority of them fell within the expected confidence intervals and therefore were determined to be Substantially Compliant. Because Molina Healthcare of Missouri did not participate in the on-site visit requirement of the EQR, they received Not Valid ratings in all measures, as the EQRO was not permitted to validate that the documentation received was produced by the Molina information systems at the St. Louis office.

3.3 Conclusions

In calculating the measures, Five of the six MCHPs have adequate information systems for capturing and storing enrollment, eligibility, and claims information for the calculation of the three HEDIS 2011 measures validated. It is assumed that Molina Healthcare of Missouri also has an adequate information system, however the EQRO could not validate this during an on-site review.

Among MCHPs there was good documentation of the HEDIS 2011 rate production process. The rate of medical record submission for the one measure allowing the use of the Hybrid Methodology was excellent, with the EQRO receiving all of the medical records requested. This review also marked the first year all six MCHPs performed a hybrid review of the measure selected, allowing for a complete Statewide comparison of those rates.

QUALITY OF CARE

The HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care received by MCHP members.

One MCHP was Fully Compliant with the specifications for calculation of this measure. Four MCHPs were substantially compliant with the specifications for calculation of this measure, while one received a rating of invalid for this measure.

For the 7-day follow up rate, three MCHPs (BA+, CMFHP and HCUSA) reported rates (52.20%, 48.34% and 50.25%, respectively) that were higher than the National Medicaid Average (44.6%) for this measure. The statewide rate for all MCHPs (45.61) was also higher than the National Medicaid Average.

This measure was previously audited by the EQRO in audit years 2006, 2007, 2009, and 2010. The 7-Day reported rate for all MCHPs in 2011 (45.61%) was a 14.45% increase overall since the rate reported in 2006 (31.16%); it is marginally higher (0.14%) than the rate reported in 2010 (45.47%).

For the 30-day follow up rate, three MCHPs (BA+, CMFHP, and HCUSA) all reported rates (73.90%, 71.43%, and 71.14% respectively) that were above than the National Medicaid Average (63.8%) for this measure. The overall MO MCHP rate (66.22%) was also higher than the National Medicaid Average.

This measure was previously audited by the EQRO in audit years 2006, 2007, 2009, and 2010. The 30-Day reported rate for all MCHPs in 2011 (66.22%) was a decrease from the rate reported in 2010 (69.50%), but remains a 13.3% increase overall since the rate reported in 2006 (52.92%).

From examination of these rates, it can be concluded that MCHP members are receiving a quality of care comparable to or higher than other Medicaid participants across the country within the 30-day timeframe the area of Follow-Up After Hospitalization for Mental Illness, but the quality of care received is not quite as high within the 7-day timeframe. In both timeframes, members are receiving a lower quality of care than the average National Commercial member. However, based on the upward trend in the rates reported, the quality of care for Follow-Up After Hospitalization for Mental Illness has significantly increased over time in Missouri for both the 7-day and 30-day timeframes, despite a slight fall in the most recent 30-day timeframe rate.

ACCESS TO CARE

The HEDIS 2011 Annual Dental Visit measure is categorized as an Access/Availability of Service measure and aims to measure the access to care received. Members need only one qualifying visit from any appropriate provider to be included in this measure calculation.

For the Annual Dental Visits measure, five of the six MCHPs reviewed were substantially compliant with the calculation of this measure, one MCHP was rated as invalid.

The Annual Dental Visits measure has been audited in the 2007, 2008, 2009, 2010, and 2011 external quality reviews. Over the course of these review periods, the rates for all MCHPs have improved a total of 9.34%, from 32.50% in 2007 to 41.84% in 2011. Although the rates have increased for the Annual Dental Visit measure, none of the MCHPs reported a rate in 2011 higher than the National Medicaid Average of 47.8%, although one MCHP (CMFHP) was close at 47.74%.

This trend shows an increased level of dental care received in Missouri by members, illustrating an increased access to care for these services for the HEDIS 2011 measurement year.

TIMELINESS OF CARE

The HEDIS 2011 Childhood Immunizations Status measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received. To increase the rates for this measure, members must receive a series of services within a very specific timeframe (i.e. prior to age 2).

For the Childhood Immunizations Status measure, five of the six MCHPs reviewed were substantially compliant with the calculation of this measure, one MCHP was rated as invalid.

Although Combination 2 for this measure was audited in 2005, the Childhood Immunizations Status, Combination 3 measure has not previously been audited by the EQRO. Therefore, no valid comparison data is available. None of the MCHPs reported a rate in 2011 higher than the National Medicaid Average of 69.9%.

This illustrates a timeliness of care for immunizations delivered to children in Missouri that is lower than the timeliness of care received by other Medicaid members across the nation.

RECOMMENDATIONS

1. The SMA should continue to encourage the use of the Hybrid Method of calculation for HEDIS measures that allow these reviews. The Hybrid review process produces higher rates on average than an Administrative method alone.
2. MCHPs with significantly lower rates of eligible members (Annual Dental Visit (MO Care), Childhood Immunizations Status (MO Care) and Follow-Up After Hospitalization for Mental Illness (MO Care) should closely examine the potential reasons for fewer members identified.
3. MCHPs with significantly lower administrative hits [Annual Dental Visit (Harmony), Childhood Immunizations Status (Harmony) and Follow-Up After Hospitalization for Mental Illness (Harmony, MO Care)] should closely examine the potential reasons for fewer services identified. This may be due to member characteristics, but is more likely due to administration procedures and system characteristics such as the proportion of members receiving services from capitated providers. Identifying methods of improving administrative hits will improve the accuracy in calculating the measures.
4. The SMA should continue to have the EQRO validate the calculation of at least one measure from year to year, for comparison and analysis of trend data.
5. MCHPs should run query reports early enough in the HEDIS season so that they may effectuate change in rates where interventions could easily be employed.
6. All MCHPs should continue to carefully review both the EQRO data request formats and the MCHP data files extracted prior to submission deadlines to ensure that data provided to the EQRO for validation is complete, accurate, and submitted in the correct format. Examination of these files prior to the submission deadlines would also allow for communication with the EQRO to clarify any questions or problems that may arise.
7. MCHPs must participate in all required portions of the External Quality Review, this is required in order for a MCHP to receive an acceptable rating.

4.0 MO HealthNet MCHP COMPLIANCE WITH MANAGED CARE REGULATIONS

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4.1 Purpose and Objectives

The External Quality Review (EQR) is conducted annually in accordance with the Medicaid Program: External Quality Review of the Medicaid Managed Care Organizations Final Rule, 42 CFR 438, Subpart E.” The EQRO uses the Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Regulations (Compliance Protocol) requirements during the review process, with an emphasis on areas where individual MCHPs have previously failed to comply or were partially compliant at the time of the prior reviews. Specifically, the MCHPs were reviewed to assess MO HealthNet MCHP compliance with the federal Medicaid managed care regulations; with the State Quality Strategy; with the MO HealthNet contract requirements; and with the progress made in achieving quality, access, and timeliness to services from the previous review year.

This year’s review is a follow-up review, the last full compliance review was done in 2009 and will include an in-depth review of Grievance and Appeal files. The MHD reviewed current policies and procedures to ensure that they were in compliance with the current contractual requirements, as well as federal regulations. The EQR Compliance Review focused on implementation of policies and procedures, as required in the Grievance and Appeals and Case Management processes. The review included case record reviews and interviews with Grievance and Appeal staff, Case Management staff, and Administrative staff. The results of the Case Management review will be reported in another section of this report as a “Special Project”. The interview tools were based on information obtained from each MCHPs’ 2011 Annual Reports to the SMA and the SMA’s Quality Strategy.

OBTAINING BACKGROUND INFORMATION FROM THE STATE MEDICAID AGENCY

Interviews and meetings occurred with individuals from the SMA from February 2012 through June 2012 to prepare for the on-site review, and obtain information relevant to the review prior to the on-site visits.

In February 2012, Compliance Review team members began discussions with the SMA to determine the direction and scope of the review. The decision was made to review the Grievance and Appeal files in the fourth quarter of the calendar year (2011). The team felt that a review of the fourth quarter was the only way to track whether the MCHPs had implemented the recommendations from the prior year's on-site reviews.

Lists of all Grievance and Appeals for the fourth quarter were obtained from the SMA, as all MCHPs are required to report these actions to the State. These lists were analyzed by the EQRO and a random case sample was requested from each MCHP that would be read and reviewed while on-site. These files would determine the questions asked during the Grievance and Appeals Staff interviews, as well as the administrative interviews. This documentation was used as a guide for the 2011 review.

The SMA also provided reviewers with a listing of all "inquiries" related to each MCHP that was received at the SMA during the fourth quarter of Calendar Year 2012. Each MCHP was provided with their respective listing and the EQRO requested to review any files or customer service notes that pertained to these "inquiries" while on-site. While on-site each MCHP was also given the opportunity to explain their approach to handling SMA inquiries. The response by each MCHP to the request for "inquiry" information is provided in this section of the report. Additionally, the SMA provided updated policy compliance information for this review to support the practice information obtained.

DOCUMENT REVIEW

Documents chosen for review were those that best demonstrated each MCHP's ability to meet federal regulations. Certain documents, such as the Member Handbook, provided evidence of communication to members about a broad spectrum of information including enrollee rights and the grievance and appeal process. Provider handbooks were reviewed to ensure that consistent information was shared regarding enrollee rights and responsibilities. Managed Care contract compliance worksheets and case management policies were reviewed as a basis for interview questions that made up the main focus of the 2011 Compliance Review. Other information, such as the Annual Quality Improvement Program Evaluation was requested and reviewed to

provide insight into each MCHPs' compliance with the requirements of the SMA Quality Improvement Strategy, which is an essential component of the Managed Care contract, and is required by the federal regulations. MCHP Quality Improvement Committee meeting minutes were reviewed. Grievance and Appeal policies and procedures were reviewed and used in assessing both the grievance and appeal records review, and in discussions with MCHP staff. In addition, interviews based on questions from the SMA and specific to each MCHP's Quality Improvement Evaluation, were conducted with administrative staff to ensure that local procedures and practices corresponded to the written policies submitted for approval. When it was found that specific regulations were "Partially Met," additional documents were requested of each MCHP. Interview questions were developed for grievance and appeals staff to establish that practice directly with members reflected the MCHPs' written policies and procedures, as well as compliance with the federal regulations. Interviews with Administrative staff occurred to address the areas for which compliance was not fully established through the pre-site document review process, and to clarify responses received from the staff interviews.

The following documents were reviewed for all MCHPs:

- State contract compliance ratings from 2011 and updated policies accepted through June 2012
- Results, findings, and follow-up information from the 2010 External Quality Review
- 2011 Annual MCHP Evaluation

CONDUCTING INTERVIEWS

After discussions with the SMA, it was decided that the 2011 Compliance Review would include interviews with Grievance and Appeals staff, Case Management Staff (under the guidelines of the "Special Project") and Administrative Staff. The goal of these interviews was to validate that practices at the MCHPs, particularly those directly affecting members' access to quality and timely health care, were in compliance with the approved policies and procedures. After completing the initial document review, it was clear that the MCHPs had made significant progress in developing appropriate and compliant written policies and procedures. The interview questions were developed using the guidelines available in the Compliance Protocol and focused on areas of concern based on each MCHP's adherence to their policy. Specific

questions were also posed, using examples from the grievance and appeals records reviewed. Corrective action taken by each MCHP was determined from the previous years' reviews. This process revealed a wealth of information about the approach each MCHP took to become compliant with federal regulations.

The interviews provided reviewers with the opportunity to explore issues not addressed in the documentation. A site visit questionnaire specific to each MCHP was developed. The questions were developed to seek concrete examples of activities and responses that would validate that these activities are compliant with contractual requirements and federal regulations.

Molina refused to participate in the on-site review and therefore, did not participate in the interviews.

ANALYZING AND COMPILING FINDINGS

The review process included gathering information and documentation from the SMA about policy submission and approval, which directly affects each MCHP's contract compliance. This information was analyzed to determine how it related to compliance with the federal regulations. Next, interview questions were prepared, based on the need to investigate if practice existed in areas where approved policy was or was not available, and if local policy and procedures were in use when approved policy was not complete. The interview responses and additional documentation obtained on-site were then analyzed to evaluate how they contributed to each MCHP's compliance. All information gathered was assessed, re-reviewed and translated into recommended compliance ratings for each regulatory provision.

REPORTING TO THE STATE MEDICAID AGENCY

During the August 2012 meeting with the SMA, preliminary findings were presented. Discussion occurred with the SMA staff to ensure that the most accurate information was recorded and to confirm that a sound rationale was used in rating determinations. The SMA approved the process and allowed the EQRO to finalize the ratings for each regulation. The actual ratings are included in this report.

COMPLIANCE RATINGS

The EQRO continues to utilize a Compliance Rating System that was developed during previous reviews. This system was based on a three-point scale (“Met,” Partially Met,” “Not Met”) for measuring compliance, as determined by the EQRO analytic process. The determinations found in the Compliance Ratings considered SMA contract compliance, review findings, MCHP policy, ancillary documentation, and staff interview summary responses that validate MCHP practices observed on-site.

If the SMA considered the policy submission valid and rated it as complete, this rating was used unless practice or other information called this into question. If this conflict occurred, it was explained in the narrative included in the individual MCHPs Compliance Section. The scale allowed for credit when a requirement was Partially Met. Ratings were defined as follows:

Met:	All documentation listed under a regulatory provision, or one of its components was present. MO HealthNet MCHP staff was able to provide responses to reviewers that were consistent with one another and the available documentation. Evidence was found and could be established that the MCHP was in full compliance with regulatory provisions.
Partially Met :	There was evidence of compliance with all documentation requirements, but staff was unable to consistently articulate processes during interviews; or documentation was incomplete or inconsistent with practice.
Not Met:	Incomplete documentation was present and staff had little to no knowledge of processes or issues addressed by the regulatory provision.

4.2 Findings

NOTE: The EQRO attempted to conduct an on-site review at the offices of Molina Healthcare of Missouri on June 25, 2012 and June 29, 2012. The EQRO review team was met at Molina’s reception desk on June 25, 2012 by its CEO and QI Director and told that Molina would not be participating in the on-site review portion of the EQR. As a result of their refusal to participate some areas of the EQR are adversely effected. This refusal impacts not only Molina’s MCHP specific findings, but also impacts some of the “All MCHP” data reporting, as Molina’s scores/rates are adding into the “All MCHP” data elements.

ENROLLEE RIGHTS AND PROTECTIONS

Subpart C of the regulatory provisions for Medicaid managed care (Enrollee Rights and Protections) sets forth 13 requirements of health plans for the provision of information to enrollees in an understandable form and language: written policies regarding enrollee rights and assurance that staff and contractors take them into account when providing services; and requirements for payment and no liability of payment for enrollees. Across all MCHPs 83.3% of the regulations were rated as “Met”, this is significantly lower than the 2010 review year when all MCHPs were 100% compliant with these standards and significantly lower than the 2008 and 2009 reviews when the All MCHP rate of “Met” was 94.87%.

NOTE: This rate is adversely affected by the score of 0.0% Met given to Molina Healthcare due to their refusal to participate in the on-site review. Removing Molina from the equation, all other MCHPs were 100% compliant with these regulatory provisions.

All MCHPs had procedures in place to ensure that members: receive pertinent and approved information [438.100(a) and 438.10(b)]; were addressed in their prevalent language [438.10(c)(3)]; have access to required interpreter services [438.10(c)(4,5)]; that all information is provided in an easily understood format [438.10 (d)(1)(i)/438.10(d)(1)(ii) & (2)]; that members are treated with respect and dignity and receive information on available treatment options and alternatives [438.100(b)(2)(iii)/438.10(g)]; and that the MCHPs are in compliance with other state requirements [438.100(d)]. All MCHP's, except Molina, were also found to have practices that met these requirements. **NOTE:** The EQRO was unable to validate the practices of Molina Healthcare, which caused their low ratings.

Three of the MCHPs (CMFHP, BA+, and HCUSA) continue to utilize a Member Advisory Committee that serves to provide insight into the issues faced by members who are attempting to obtain healthcare services. These MCHPs incorporated member suggestions into their operations and marketing materials. These activities were indicators of the MCHPs' commitment to member services and to ensuring that members have quality healthcare.

All MCHPs continued to operate programs for the provision of behavioral health services. Four

of the MCHPs subcontract with Behavioral Health Organizations (BHO) for these services. One MCHP (MO Care) utilize an “in-house” model for the provision of behavioral health services. MO Care uses a system of integrated case management and maintenance of the provider delivery system within their MCHP structure.

COMPLIANCE INTERVIEWS

Interviews were held at each MCHP (except Molina) with case management staff. Interviews were not held at Molina due to the MCHP's refusal to participate in the on-site review. At all other MCHPs, additional interviews occurred with Administrative staff to obtain clarification on issues identified from the policy and document reviews, and additionally to clarify some responses received from the case managers. Interview questions were developed from the review of each MCHP's case management policy and from the case records reviewed prior to the time of the on-site review. These interview questions were specific to each MCHP, and focused on issues that might compromise compliance with required case management activities. The specific findings of these interviews are reported in the “Special Project” section of this report and each MCHP's specific questions are included in the individual sections of this report.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT: ACCESS STANDARDS

Subpart D of the regulatory provision for Medicaid managed care sets forth 17 regulations governing access to services. These regulations call for: the maintenance of a network of appropriate providers including specialists; the ability to access out-of-network services in certain circumstances; adequate care coordination for enrollees with special healthcare needs; development of a method for authorization of services, within prescribed timeframes; and the ability to access emergency and post-stabilization services. There were no items rated as “Not Met” (see Table 17). Across all MCHPs, 75.49% of the regulations were “Met” which is consistent with the 2010 rate and a **decrease** from the 2009 rate of 86.7%. Two of the MCHPs (BA+ and MO Care) were found to be 82.35% compliant; two (CMFHP and HCUSA) were found to be 76.5%; Harmony was found to be 70.6% compliant; and Molina was rated as 64.71% compliant.

- Both BA+ and MO Care improved over their 2010 rate of 76.5%. BA+ attributed the improvement to the enhancements to their case management system which went “live” in 2011.

- CMFHP, HCUSA and Harmony received the same ratings as they did in 2010. At these MCHPs, no improvements were noted in the case record reviews. Many of the case records reviewed did not include substantial evidence of complete adherence to policy or complete documentation of the assessment process and services provided.
- Molina's low rating is directly related to their refusal to participate in the on-site review. By not participating, the EQRO was unable to interview case management or administrative staff to follow up on questions that had arisen after reviewing cases and/or documentation supplied by the MCHP.

The consistent rating for the Access Standards compliance rate is directly attributable to the findings of the Case Management Special Project (this is discussed in greater detail in Section 4 of this report).

All MCHPs had policies and practice that reflected the members' right to a second opinion and a third opinion if the first two disagreed [438.206(b)(3)]. Other areas where all MCHPs were 100% compliant with complete and approved policy were Adequate and Timely Service and Cost Sharing for Out of Network Services; Timely Access to Care, Provider Cultural Competency; Timeframes for Decisions for Expedited Authorizations; and Emergency and Post-Stabilization Services. Throughout this review period, all MCHPs reported incidents where they found providers who were familiar with members' cultural and language needs. Sensitivity to and respect for members' cultural needs was an area where the MCHPs excelled.

Table 17 – Subpart D: Quality Assessment and Performance Improvement: Access Standards

Federal Regulation	MO HealthNet MCHP						All MO HealthNet MCHPs			
	BA+	CMFHP	Harmony	HCUSA	MO Care	Molina	Number Met	Number Partially Met	Number Not Met	Rate Met
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	1	2	2	2	5	1	0	83.3%
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2	2	2	2	6	0	0	100.0%
438.206(b)(3) Second Opinions	2	2	2	2	2	2	6	0	0	100.0%
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2	2	2	2	6	0	0	100.0%
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2	2	2	2	6	0	0	100.0%
438.206(c)(1)(i-vi) Timely Access	2	2	2	2	2	2	6	0	0	100.0%
438.206(c)(2) Provider Services: Cultural Competency	2	2	2	2	2	2	6	0	0	100.0%
438.208(b) Care Coordination: Primary Care	2	1	0	1	1	1	1	4	1	16.7%
438.208(c)(1) Care Coordination: Identification	2	1	1	1	2	1	2	4	0	33.3%
438.208(c)(2) Care Coordination: Assessment	1	1	1	1	1	1	0	6	0	0.0%
438.208(c)(3) Care Coordination: Treatment Plans	1	1	0	1	1	1	0	5	1	0.0%
438.208(c)(4) Care Coordination: Direct Access to Specialists	1	2	2	2	2	1	4	2	0	66.7%
438.210(b) Authorization of Services	2	2	2	2	2	2	6	0	0	100.0%
438.210(c) Notice of Adverse Action	2	2	2	2	2	1	5	1	0	83.3%
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2	2	2	2	6	0	0	100.0%
438.210(e) Compensation of Utilization Management Activities	2	2	2	2	2	2	6	0	0	100.0%
438.114 Emergency and Post-Stabilization Services	2	2	2	2	2	2	6	0	0	100.0%
Number Met	14	13	12	13	14	11	77	23	2	75.49%
Number Partially Met	3	4	3	4	3	6				
Number Not Met	0	0	2	0	0	0				
Rate Met	82.35%	76.47%	70.59%	76.47%	82.35%	64.71%				

Note: 0 = Not Met; 1 = Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient MCHPs (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2011 External Quality Review Monitoring MCHPs Protocols.

Evidence existed of efforts to inform members of available providers, urgent care centers, and hospitals through presentations at community events and newsletters. The need to ensure that members received appropriate referrals to PCPs and specialty providers was clearly reflected in the interviews. Required documentation and approved policies did exist in all areas for all MCHPs.

All six of the MCHPs had complete policy and Provider Manual language in the area of emergency and post-stabilization services [438.114]. The MCHPs made efforts to ensure that the problems they experienced did not affect services to members. All MCHPs provided evidence of strong relationships with their providers and maintained strong communication with them particularly in solving member service problems.

Harmony reported that they are continuing active recruitment efforts in the outlying counties in the region. However, their network has improved compared to the prior year's review.

It is believed that the MCHPs make a concerted effort to ensure that members have appropriate and timely access to services. They continued to express concern over the shortage of specialists in the areas of orthopedic surgery, pediatric neurology, rheumatology, and child/adolescent psychiatrists. All MCHPs (that were interviewed) reported utilizing out-of-network providers and often paying commercial or **higher** rates to obtain these services.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT: STRUCTURE AND OPERATION STANDARDS

There are 10 Structure and Operations Standards for ensuring compliance with State policies and procedures for the selection and retention of providers, disenrollment of members, grievance systems, and accountability for activities delegated to subcontractors. Across all MCHPs 83.3% of the regulations were rated as “Met”, this is **significantly lower** than the 2010 review year when all MCHPs were 100% compliant with these standards and **lower** than the 2008 and 2009 reviews when the All MCHP rate of “Met” was 95% and 93.3% respectively.

NOTE: This rate is adversely effected by the score of 0.0% Met given to Molina Healthcare due to their refusal to participate in the on-site review. Removing Molina

from the equation, all other MCHPs were 100% compliant with these regulatory provisions.

Where interviews were conducted, it was evident that the Provider Services departments of the MCHP exhibited a sound and thorough understanding of the requirements for provider selection, credentialing, nondiscrimination, exclusion, and Managed Care requirements. Five of the six MCHPs were 100% compliant with these regulations. This included Provider Selection [438.214(d) and 438.214(e)]; Timeframes [438.56(e)]; and disenrollment. The staff interviewed at each MCHP understood the requirements for disenrollment. All of the MCHPs described credentialing and re-credentialing policies that exceeded the requirements of the regulations. All MCHPs have developed policy and procedures that comply with NCQA criteria. Providers were willing to submit to these stricter standards to maintain network qualifications in both the MCHPs and other commercial networks. All of the MCHPs (100.0%) had all required policies and practices in place regarding credentialing.

All MCHP's, except Molina, were also found to have practices that met these requirements. Molina's refusal to participate in the on-site review caused the EQRO to be unable to validate the practices of Molina Healthcare and caused their low ratings.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT: MEASUREMENT AND IMPROVEMENT

There are 12 Measurement and Improvement Standards addressing the selection, dissemination, and adherence to practice guidelines; the implementation of PIPs; the calculation of performance measures; the evaluation of the availability of services and assessment techniques for enrollees with special healthcare needs; and the maintenance of information systems that can be effectively used to examine service utilization, grievances and appeals, and disenrollment. A total of 81.82% of the criteria were "Met" by MCHPs, which is a **decrease** that indicates fewer federal requirements being met as compared to the 93.9% rate in 2010 and the 2009 rate of 92.4%. This number again reflects that one MCHP (Molina) did not participate in the onsite review. Only one MCHP (BA+) met all the requirements (100%) in this area. Four MCHPs (CMFHP, Harmony, HCUSA, and MO Care) received a rating of 90.90% in this area, each of

these MCHPs had one “Partially Met” rating. The areas that were Partially Met were either difficulty with the Performance Improvement Project process (CMFHP, Harmony, MOCare) or failure to submit Performance Measure data in a format requested (HCUSA). One MCHP (Molina) received a rating of 27.27% due to the EQRO’s inability to validate the practice of the MCHP during the onsite review.

Table 18 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement

Federal Regulation	MO HealthNet MCHP						All MO HealthNet MCHPs			
	BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Rate Met
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2	2	2	1	5	1	0	83.3%
438.236(c) Practice Guidelines: Dissemination	2	2	2	2	2	1	5	1	0	83.3%
438.236(d) Practice Guidelines: Application	2	2	2	2	2	1	5	1	0	83.3%
438.240(a)(1) QAPI: General Rules	2	2	2	2	2	2	6	0	0	100.0%
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCHP Quality Improvement and PIPs	2	1	1	2	1	1	2	4	0	33.3%
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	2	1	2	1	4	2	0	66.7%
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2	2	2	2	6	0	0	100.0%
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2	2	2	2	6	0	0	100.0%
438.240(e) QAPI: Program Review by State	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
438.242(a) Health Information Systems	2	2	2	2	2	0	5	0	1	83.3%
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2	2	2	0	5	0	1	83.3%
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2	2	2	0	5	0	1	83.3%
Number Met	11	10	10	10	10	3	54	9	3	81.8%
Number Partially Met	0	1	1	1	1	5				
Number Not Met	0	0	0	0	0	3				
Rate Met	100.00%	90.9%	90.9%	90.9%	90.9%	27.27%				

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCHP's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MO HealthNet Managed Care Program. This percent is calculated for the regulations that are applicable to the MO HealthNet Managed Care Program.

0 = Not Met; 1 = Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient MCHPs (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2011 External Quality Review Monitoring MCHPs Protocols.

During the on-site reviews it was evident to the reviewers that practice guidelines have become a normal part of each MCHPs' daily operation. Practice guidelines are in place and the MCHPs are monitoring providers to ensure their utilization. All six of the MCHPs that participated in the onsite review met all the requirements for adopting, disseminating and applying practice guidelines. Although Molina's policy is to use Practice Guidelines, they have changed medical directors since the 2010 review and the EQRO was unable to question the new Medical Director during the on-site review to inquire about the practice guidelines being utilized under the new Medical Director.

All six MCHPs (100.0%) used nationally accredited criteria for utilization management decisions [438.240(b)(3)]. The tools the MCHPs reported using included the InterQual Clinical Decision Support Tool, LOCUS/CALOCUS (Level of Care Utilization System/Child and Adolescent Level of Care Utilization System) for utilization management decisions in the provision of behavioral health services and the Milliman Care Guidelines. These sources provided evidence-based criteria and best practice guidelines for healthcare decision-making. The MCHP staff was able to articulate how they utilized these tools and apply them to member healthcare management issues. The case management cases reviewed at Molina contained evidence on the use of these guidelines.

All MCHPs, that participated in the on-site review, maintained prior year levels or improved in the section of the protocol involving Validating Performance Measures and Health Information Systems. As noted above, issues exist for three MCHPs in the area of Validating Performance Improvement Projects. Detailed findings and conclusions for these items are provided in previous sections of this report and within the MCHP summaries.

GRIEVANCE SYSTEMS

The EQRO was asked by the SMA to focus closely on the area of Grievances and Appeals during this Followup compliance review. Subpart F of the regulatory provisions for Medicaid managed care (Grievances and Appeals) sets forth 18 requirements for notice of action in specific language and format requirements for communication with members, providers and subcontractors regarding grievance and appeal procedures and timelines available to enrollees

and providers.

The EQRO developed a methodology whereby, a sample of Grievance and Appeal files were reviewed on-site by the EQRO Project Director. A listing of all Grievance and Appeals, as reported by the MCHPs to the SMA, was obtained for 4Q2011. A number of these files were then randomly selected for review at the on-site visit. Each MCHP was provided a listing of the files to be reviewed one week prior to the on-site review.

Once on-site, these files were reviewed for compliance with Subpart F of the regulatory provisions for Medicaid managed care (Grievances and Appeals) and the MCHPs' contract for the provision of MO HealthNet services with the SMA.

CONCLUSION

Although all plans had policy that was complete and approved by the SMA, at most of the MCHPs, a review of the files showed a lack of adherence to those policies and procedures (see Table 20). **NOTE:** Molina did not participate in the onsite review, however, the EQRO reviewed all of the Grievance and Appeals files that Molina supplied to the EQRO as of the date of the scheduled on-site review. Twenty-one files were not received as of that date and were therefore not reviewed.

Table 19 – Grievance and Appeals records reviewed by MCHP

MCHP	# of records reviewed	# with issues	% with issues	% Correct
Blue-Advantage Plus	30	2	6.67%	93.33%
CMFHP	32	6	18.75%	81.25%
Harmony	39	6	15.38%	84.62%
HCUSA	30	1	3.33%	96.67%
MO Care	40	0	0.00%	100.0%
Molina	50	21	42.0%	58.0%
Statewide rate	221	36	16.29%	83.71%

Additionally, it was determined that some of the mandatory language required by the State contract did not rise to meet the requirements of the regulatory provisions outlined in the Federal Protocols. Specifically: 1) the language included in each MCHPs' member handbook,

does not delineate the MCHPs' availability to assist members in filing a Grievance and/or Appeal, and 2) the mandatory language included in each MCHPs' member handbook, does not indicate that the MCHP will supply the member with the State or Federal regulations that support any action the MCHP may have taken.

OPPORTUNITIES FOR IMPROVEMENT

The issues found during the file reviews included: Missing letters of acknowledgement to grossly improper grammar in Appeals letters; Use of language that does not meet appropriate grade-level requirements; and Timelines of disposition of grievance or appeal that did not meet standards. These issues will be described in each MCHP's individual plan Compliance section of this report.

The MCHP ratings ranged from "Partially Met" to "Not Met" in the category of 438.404 (a) Grievance System: Notice of Action-Language and Format. The All MCHPs rating in this category was 75.9% a **decrease** from prior review years' findings of 76.2% and a **significant decrease** from the 2009 rating of 100% compliance.

NOTE: This **lower** overall rating is mainly attributable to Molina's refusal to participate in the on-site review and Molina only provided 29 of the 50 requested Grievance and Appeals files at the time of the scheduled onsite review. If Molina is removed from the equation, the overall rating for All MCHPs is 88.9% compliance.

Four of the five MCHPs (BA+, Harmony, HCUSA and MO Care) showed improvement in the area of Grievance Systems over the 2010 review year. However, only one MCHP (MO Care) received a rating of 100% compliance in the area of Grievance Systems for the 2011 review.

Two of the MCHPs (BA+ and Harmony) were rated as "Not Met" with category 438.404(b) Grievance System: Notice of Action - Content as their files showed additional issues with a significant number of the NOA letters examined during the on-site.

There were no deficiencies in the Grievance System policy submission for all six MCHPs. However, as noted earlier, the EQRO feels that the mandatory language in the “Continuation of Benefits” clause of the NOA letter and the inclusion of all legal aid offices that serve Missouri are unnecessarily confusing.

At five of the six MCHPs, interviews were conducted with the specific units or persons who respond to member grievances and appeals and provider complaints, grievances and appeals during all on-site reviews. Most plans described a system where the number and type of cases or issues are reflected in the notes that Case Management staff record on all member contacts. These processes are resulting in timely processing of the complaints, grievances, and appeals. It appears that all MCHP staff is aware that it is the member’s decision to file a grievance or appeal. However, they record their conversations regardless of the choices made. Staff states that if a member chooses not to file a grievance or appeal, and it appears that the MCHP or a provider had an issue with a member, they send these notes on to the Grievance and Appeal Unit, and/or to Provider Services for follow-up to ensure that all issues are resolved. **NOTE:** The EQRO is unable to determine Molina’s practice regarding responses to member grievances and appeals, due to their refusal to participate in the on-site review.

Table 20 – Subpart F: Grievance Systems

Federal Regulation	BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Rate Met
438.402(a) Grievance and Appeals: General Requirements	2	2	2	2	2	2	6	0	0	100.0%
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2	2	2	1	5	1	0	83.3%
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2	2	2	1	5	1	0	83.3%
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2	2	2	2	6	0	0	100.0%
438.404(a) Grievance System: Notice of Action - Language and Format	1	1	1	2	2	0	2	3	1	33.3%
438.404(b) Notice of Action: Content	1	1	1	2	2	0	2	3	1	33.3%
438.404(c) Notice of Action: Timing	2	2	2	1	2	0	4	1	1	66.7%
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	1	2	2	0	4	1	1	66.7%
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2	2	2	0	5	0	1	83.3%
438.408(a) Resolution and Notification: Basic Rule	2	2	1	2	2	0	4	1	1	66.7%
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2	2	2	1	5	1	0	83.3%
438.408(d,e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	1	2	2	2	2	0	4	1	1	66.7%
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2	2	2	1	5	1	0	83.3%
438.410 Expedited Resolution of Appeals	2	2	2	2	2	1	5	1	0	83.3%
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	2	2	2	1	5	1	0	83.3%
438.416 Recordkeeping and Reporting Requirements	2	2	2	2	2	1	5	1	0	83.3%
438.420 Continuation of Benefits while Appeal/Fair Hearing Pend	2	2	2	2	2	1	5	1	0	83.3%
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2	2	2	1	5	1	0	83.3%
Number Met	15	16	14	17	18	2	82	19	7	75.9%
Number Partially Met	3	2	4	1	0	9				
Number Not Met	0	0	0	0	0	7				
Rate Met	83.3%	88.9%	77.8%	94.4%	100.0%	11.1%				

Note: 0 = Not Met; 1 = Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient MCHPs (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2010 External Quality Review Monitoring MCHPs Protocols.

STATE INQUIRY LOG REVIEW

The EQRO was asked by the SMA to review each MCHP's approach to dealing with any inquiries that were made directly to the SMA regarding MO HealthNet Managed Care MCHPs. The EQRO obtained a listing of all inquiries the SMA received during the 4QCY2011 and sent a request to each MCHP to supply any information they had that pertained to these inquiries to the EQRO at the onsite review. The SMA had three goals for this review:

- 1) To gather information regarding whether each MCHP had a process in place for dealing with these inquiries;
- 2) To document what process was used; and
- 3) To determine how each of the inquiries on the list were handled,
 - a. To report whether these inquiries resulted in a formal Grievance or Appeal and if they did not, whether the EQRO believed the formal Grievance and Appeal process should have been utilized.

A total of 96 inquiries were forwarded to the MCHPs a week prior to the onsite review. The MCHP's were asked by the EQRO to provide any and all documentation they had regarding these inquiries. This information was reviewed by the EQR Project Director and analyzed based on the goals stated above.

Four of the six MCHP's (BA+, CMFHP, HCUSA and MO Care) were able to provide detailed documentation for all of the inquiries that were received at their MCHP during 4QCY11. One MCHP (Harmony) was able to articulate a process for dealing with the inquiries, but was unable to produce any documentation regarding the MCHP's actions specific to the seven inquiries they received. One MCHP (Molina) stated in writing "unable to locate" as their response to the EQRO's request for information on the 20 inquiries the SMA had logged for that MCHP during 4QCY11.

Of the 96 inquiries reviewed, 69 files/notes were supplied to the EQRO detailing how the MCHP resolved the issue. Of those 69 files/notes, 2 were documented to have **resulted in a formal Appeal**. In the opinion of the EQRO, 4 additional files **should have resulted in a formal grievance/appeal and did not**. A breakdown of the remaining 63 inquiries by category of the issues documented by the MCHP is below.

- No file found – 2 inquiries
- Resolved by SMA – 4 inquiries
- Legislative Inquiry – 7 inquiries
- Dental denial – MHD response – 8 inquiries
- Out of Network Authorizations – 9 inquiries
- Claims/Billing – 15 inquiries
- Eligibility/Enrollment – 18 inquiries

4.3 Conclusions

Across all MCHPs there continues to be a commitment to improving and maintaining compliance with federal regulations. With the exception of Molina, there are only a few regulations rated as “Not Met.” All other individual regulations were rated as “Met” or “Partially Met.” Unlike prior years, all MCHPs were not 100% compliant with any of the areas reviewed this year. **NOTE:** In the areas of Enrollee Rights and Protections and Structure and Operations Standards all MCHPs would have been 100% compliant if the rating for Molina was removed.

For the second year in a row, none of the six MCHPs were 100% compliant with all requirements. This is attributable to the in-depth review of the plans’ Grievance and Appeals files and Case Management Special Project review. All MCHPs were unable to demonstrate case management information that fully exhibited compliance with the aspects care coordination.

All of the MCHPs exhibit attention to becoming and remaining compliant with the SMA contractual requirements and the corresponding federal regulations. All sources of available documentation, interviews, and observations at the on-site review were used to develop the ratings for compliance. The EQRO comments were developed based on review of this documentation and interview responses. Several of the MCHPs made it clear that they used the results of the prior EQR to complete and guide required changes, this was evident in many of the areas that the EQRO noted improvement. The following summarizes the strengths in the

areas of Access to Care, Quality of Care and Timeliness of Care.

QUALITY OF CARE

For all the MCHPs who participated in the onsite review, all of the 13 regulations for Enrollee Rights and Protections were 100% “Met.” Communicating Managed Care Members’ rights to respect, privacy, and treatment options, as well as communicating, orally and in writing, in their own language or with the provision of interpretive services is an area of strength for all MCHPs. These MCHPs were aware of their need to provide quality services to members in a timely and effective manner.

For all the MCHPs who participated in the onsite review, all of the 10 regulations for Structure and Operations Standards were 100% “Met.” These included provider selection, and network maintenance, subcontract relationships, and delegation. The MCHPs had active mechanisms for oversight of all subcontractors in place. This is the second year in a row that these five MCHPs maintained a 100% rating in this set of regulations. These MCHPs articulated their understanding that maintaining compliance in this area enabled them to provide quality services to their Managed Care members.

Molina Healthplan of Missouri refused to participate in the scheduled onsite review at their offices in St. Louis, MO on Monday, July 25, 2012, due to this decision, the EQRO could not effectively evaluate the Quality of Care delivered to the Molina members.

ACCESS TO CARE

Five of the six MCHPs’ compliance with the 17 federal regulations concerning Access Standards **improved** or remained **consistent** during this year’s review. Two MCHPs were 82.35% compliant, two MCHPs were 76.5% compliant and one was found to be 70.6% compliant. One MCHP (Molina) received a much lower rating for compliance with Access Standards of 64.71%, this is largely attributable to their lack of participation in the onsite review.

Although the EQRO observed that most of the MCHPs had active case management services in place, the records requested did not always contain information to substantiate these observations. Each MCHP described measures they used to identify and provide services to MO HealthNet Managed Care Members who have special healthcare needs. Five of the MCHPs could describe efforts to participate in community events and forums to provide education to members regarding the use of PCPs, special programs available, and how to access their PCP and other specialist service providers that might be required. The MCHPs were crucially aware of their responsibility to provide access to care and services, and to communicate complete information on this topic to their members. One area of concern is care coordination. Although all six MCHPs had all required policy in place, none of them were able to demonstrate through chart review that they had fully compliant care coordination processes in place.

TIMELINESS OF CARE

Only three of the 12 regulations for Measurement and Improvement were 100% “Met.” However, only one of the six MO HealthNet MCHPs met all of the regulatory requirements. All five of the MCHPs that participated in the onsite review adopted, disseminated and applied practice guidelines to ensure sound and timely healthcare services for members. These MCHPs used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilization management.

Several MCHPs continue to use member and community based quality improvement groups to assist in determining barriers to services and methods to improve service delivery. The Case Management departments reported integral working relationships with the Provider Services and Relations Departments of the MCHPs, this was not always evident in the documentation reviewed. All front line staff and administrators interviewed exhibited a commitment to relationship building, as well as monitoring providers to ensure that all standards of care were met and that good service, decision-making, and sound healthcare practices occurred on behalf of members. The MCHPs, that participated in the onsite review, all provided examples of how

these relationships served to ensure that members received timely and effective healthcare. The MCHP staff would contact providers directly to make appointments whenever members expressed difficulty in obtaining timely services.

Only two of the 18 regulations for Grievance Systems were 100% “Met” for all of the MCHPs. These regulations all pertained to the written policy and procedure of the MCHPs. All five of the MCHP’s who made Grievance and Appeal files available to the EQRO during the onsite review improved greatly in the compliance ratings they received in this category. The practice at these five MCHPs was much closer to matching the written policy than in the prior year’s review.

MCHPs remained invested in developing programs and providing services beyond the strict obligations of the contracts. Preventive health and screening initiatives exhibited a commitment to providing the best healthcare in the least invasive manner to their members. Partnerships with local universities and medical schools provided opportunities to obtain cutting-edge and occasionally experimental treatment options, which would not otherwise be available to members. The MCHPs observed that these efforts combined to create a system that allowed members timely access to quality healthcare.

RECOMMENDATIONS

1. MCHPs should continue to submit all required policy and procedures in a timely manner. This is the first review year when all MCHPs have approved policy and procedures. This is likely due to the requirement that all MCHPs be NCQA accredited.
2. All MCHPs need to examine their case management programs. Attention to the depth and quality of case management services should be a priority for every MCHP. Goals should be established for the number of members in case management and the outcomes of the delivery of case management services. Continued attention must be applied to ensure the EQRO receives documentation as requested to validate that these services are occurring.

3. The Grievance Systems must be closely monitored at all the MCHPs to ensure compliance with the Federal regulations and the State contract. Content of letters and member handbooks must be understandable to the Managed Care members and meet the Federal and State requirements.
4. The Mandatory Language contained in all MCHPs' member handbooks should be reviewed. The EQRO was unable to find language detailing the MCHPs' availability to assist members when filing appeals and/or grievances (other than language assistance).
5. The SMA should establish a policy that all MCHPs should follow when dealing with State Inquiries, additionally, the SMA should allow the MCHPs to resolve any inquiries dealing with aspects of member care. If the SMA resolves member care issues, outside of the State Fair Hearing or other State mandates, they are infringing on the MCHPs control of member care.
6. All MCHPs must participate in every required aspect of an External Quality Review.

5.0 MO HealthNet MCHP SPECIAL PROJECT CASE MANAGEMENT PERFORMANCE REVIEW



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4.1 Purpose and Objectives

The MO HealthNet Division (MHD) asked the EQRO to conduct a special project to follow up on the Managed Care MCHPs' (MCHP) compliance with federal regulations regarding quality, timeliness, and access to health care services related to the provision of case management services. The objective of this special project is to complete an in-depth follow-up review of Case Management by assessing the MCHPs' improvement in service delivery and recording keeping. The EQRO also evaluated the MCHP's compliance with the federal regulations and Managed Care contract as it pertained to Case Management.

The focus of this review was:

- Assessing the MCHPs' attention and performance in providing case management to pregnant members, children with special health care needs, and children with elevated blood lead levels;
- Evaluating compliance with the Managed Care contract; and
- Exploring the effectiveness of case management activities provided by the MCHPs on cases they report as open in their system.

METHODOLOGY

The review included the following components:

- Review of each MCHP's case management policy and procedures;
- Case record reviews of thirty (30) cases from listings received from the MCHPs of all open and active cases in the fourth quarter of 2011; and
- On-site interviews with case management staff and MCHP administrative staff.

The MHD Managed Care staff reviews and approves all MCHP policy. Questions developed by the EQRO in the case record review process focused on compliance with the requirements of case management as set out in the Managed Care contract and as developed from the actual record review. Case review results reflected how well individual files met both the MCHP's policy requirements and those of the Managed Care contract.

CASE RECORD REVIEWS

A listing of open and active cases from the fourth quarter of 2011 was requested from the MCHPs. A random sample of thirty (30) cases per MCHP from the listings provided was requested for review. The MCHPs sent all requested case records.

The records were reviewed by EQRO Consultant Myrna Bruning, R.N, and EQRO Assistant Project Director, Mona Prater. A case review form, pre-approved by the SMA, was used to assess the quality of the medical case records received.

ON-SITE INTERVIEWS

The purpose of the on-site interviews was to:

- Evaluate the case managers' knowledge of the MHD contractual requirements of their position; and
- Determine methods used by case managers to operationalize policy in their daily activities.

The interviews occurred at each MCHP, with the exception of Molina Health Care, as follows:

1. Interviews were conducted during the on-site review. Interview questions were based on the Managed Care contract requirements and the outcomes of the record reviews. Each interview tool addressed issues specific to the MCHP's review results and included general questions for each MCHP's staff based on contract requirements.
2. Interviews were conducted with direct service staff at each MCHP. Each interviewee's presence was requested prior to the date of the on-site review. If staff was not available, substitutions were accepted.
3. Interviews were not conducted at Molina Health Care due to their refusal to participate in the on-site review.

DOCUMENT REVIEW

Case Management Record Review

The case management record review was designed to verify that case management activities were conducted in compliance with the Managed Care contract and with all applicable federal policies. The results are divided into categories that summarize these reviews. A comparison with the results of the 2010 case record review, for each category is also part of this evaluation.

The case files were evaluated based on the Case Management requirements found in the October 1, 2009 Managed Care contract.

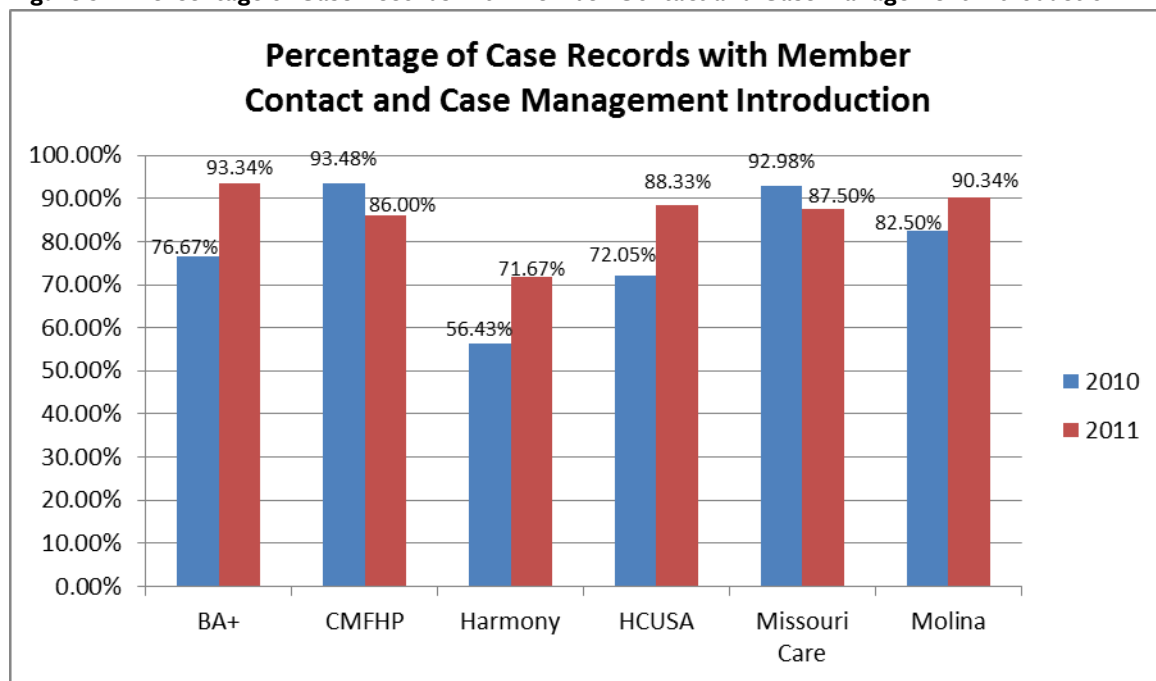
4.2 Findings

The findings include the results of the case reading and on-site interviews for each MCHP. The charts in this section include the results of the case record reviews and information obtained during the case manager interviews. The standards addressed in each section were developed as part of the case record review tool, approved by the SMA. This tool and these standards reflect the requirements for case management, case record maintenance, and transition planning from the October 1, 2009 Managed Care Contract.

CASE RECORD REVIEW RESULTS

INTRODUCTION TO CASE MANAGEMENT

Figure 31 - Percentage of Case Records with Member Contact and Case Management Introduction



There are four standards used to assess the category of Introduction to Case Management. The records and recording must include:

1. Identifying information used to locate and maintain contact with the member;
2. Case opening – after receipt of referral was a case opened for assessment and service

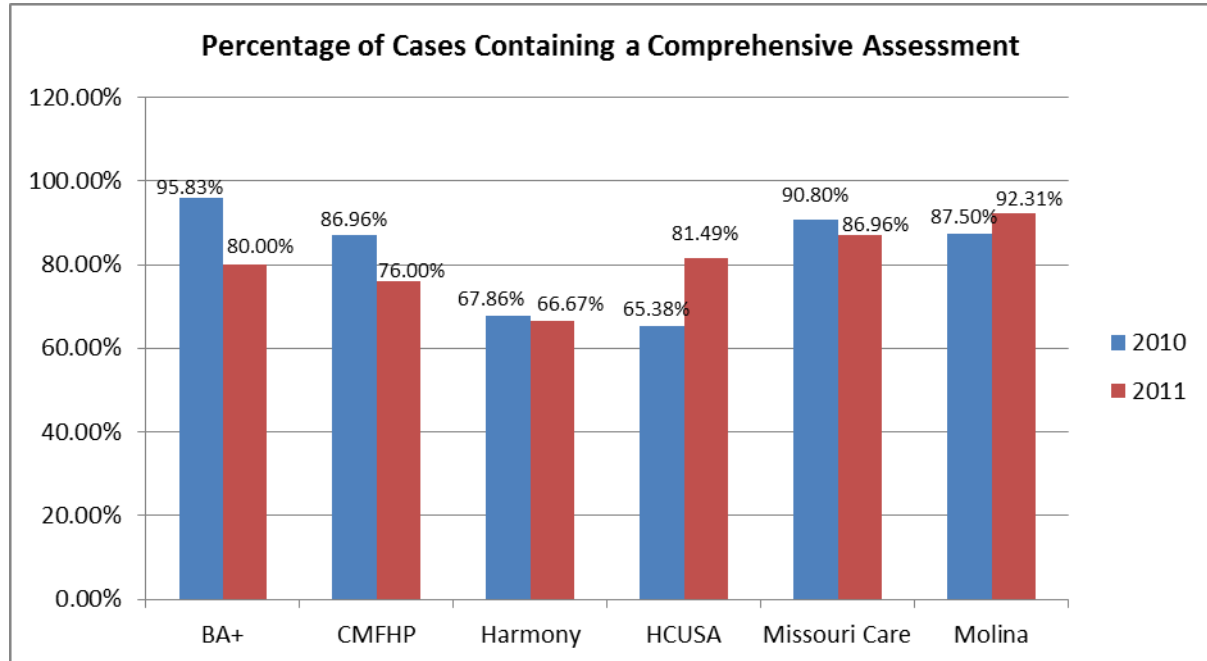
delivery;



3. Introduction to Case Management – did the case manager explain the case management process to the member; and
 4. Acceptance of Services – did the member indicate they agreed to the MCHP providing case management services, thereby allowing on-going involvement.
- Obtaining referrals, locating members, introducing them to the case management process, and eliciting their acceptance of case management services are essential functions for case managers.
 - Four of the six MCHPs (BA+, Harmony, HCUSA, and Molina) improved. in all four standards from 2010 to 2011.
 - Two MCHPs' percentages declined (CMFHP and Missouri Care). Both achieved 100% compliance in the area of obtaining identifying information and opening cases during the 2010 review.
 - EQR case reviewers identified instances where efforts to regain contact with members were limited. In these cases, the case manager did not explore alternative methods of contact, such as contact with provider offices to request current demographic information.
 - Case managers receive referrals from a variety of sources internal and external to the MCHP.
 - Members have the option of declining case management services. In most of the records reviewed, members contacted welcomed the support that case management offers. In the majority of instances case management services were accepted.
 - Case managers are required to explain the nature of the case management relationship, the contact they will have with the member and the services available. Case managers must request approval to discuss the case with a third party, if appropriate, discuss the availability of a complaint process, and explain any contacts with the providers involved.
 - This activity occurred in most cases and was reflected in the case record information, along with the member's agreement to accept services.
 - Cases that were referred to several MCHPs (Molina, HCUSA, and Harmony) due to Elevated Blood Lead Levels (EBLL) indicated no member contact.
 - These cases remained open in the MCHP's system and the case manager made contacts with public health agencies, physicians, and FQHC's. In these cases the member was never contacted directly, and actual case management services were not provided to members.

ASSESSMENT

Figure 32 - Percentage of Cases Containing a Comprehensive Assessment



The standards used to evaluate the assessment of the member's service needs include:

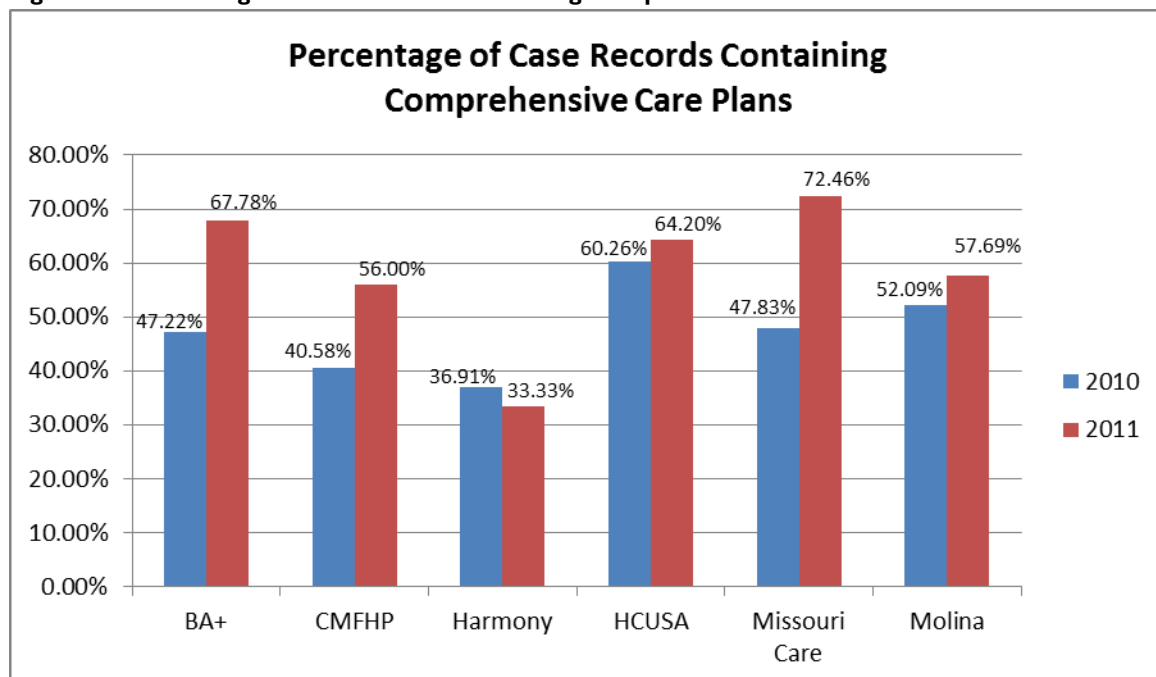
1. Completion within specified time frames; and
 2. Inclusion of a comprehensive assessment in the file.
- All records and recording must include an assessment tool or questions.
 - The records from two MCHPs (HealthCare USA, Molina) provided more assessment information than in the previous review.
 - In four of the MCHP's records (BA+, CMFHP, Harmony, and Missouri Care), the assessment tool or questions were found in fewer case records in 2011 than in 2010.
 - Case notes mentioned the assessment process, in some records, but the actual assessment tool or questions/responses were not available.
 - These assessments are to be comprehensive in nature for all MCHPs. This requirement did not improve in 2011.
 - In the cases that included assessment tools, standardized questions were asked of all participants. Very few records included notes indicating that the case manager evaluated the answers and utilized this information in the work with the member.



- In one case, during the assessment process, a member gave answers indicating the existence of a behavioral health issue. However, case notes and results of the assessment did not indicate that the availability of behavioral health services was discussed with the member.
- Although the assessments are used to create a care plan for the member, any direct extrapolation of information into case activities was limited.
- The case notes did not reflect a correlation between the information obtained from the standardized assessment questions and the ongoing case management services.

CARE PLANNING

Figure 33 - Percentage of Case Records Containing Comprehensive Care Plans



The standards used to evaluate appropriate care planning require:

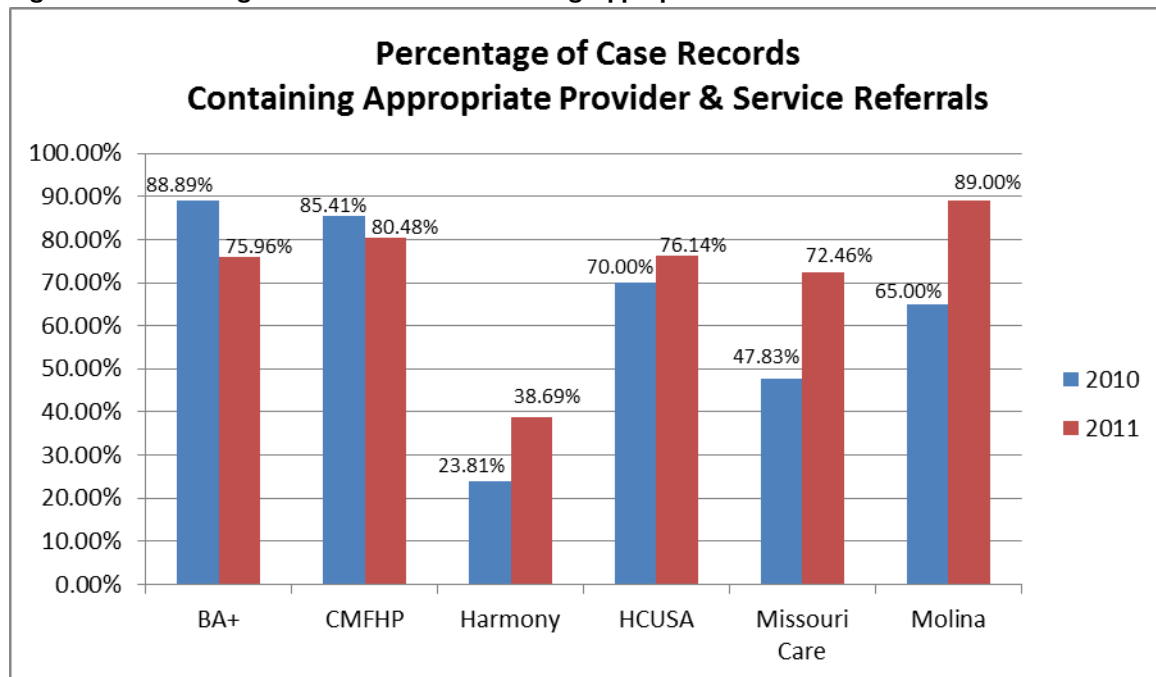
1. A care plan; and
2. A process to ensure that the primary care provider, member (their primary care giver, parent or guardian), and any specialists treating the member are involved in the development of the care plan.

With one exception (Harmony) there was significant improvement from the 2010 review in the case records that included care plans.

- The care plans seen for the 2011 review were often system-generated directly from the assessments.
- In cases that did not include the assessment tool, care plans were part of the record or the case notes.
- In some cases, particularly those open for an extended period of time, the record included updated plans and references to the plan throughout the case notes, indicating specific areas of success, new issues that developed, and areas where work with the member continued.
- For the 2011 review, the number of care plans, or case notes, indicating that the member was included in care plan development increased.
 - Notes reflected that specific issues were discussed and plans to meet members' needs were included.
 - In some case records, that did not include the actual care plan, there were specific case notes discussing a conversation with the member about the plan and the activities that were to occur. In these instances the reviewers credited the MCHP for member inclusion in the process.
- Inclusion of the PCP or specialist in the care planning process continues to be an area of concern.
 - During the 2011 review there were letters in some of the records indicating that the care plan was mailed to the PCP or the physician most actively involved with the member (in a number of cases this was the OB/GYN). Three MCHPs contacted the PCP more than 50% of the time (HealthCare USA, Missouri Care, Molina) to inform them of the case manager's involvement and to present a care plan for their review.
 - The case managers at two of the MCHPs (HealthCare USA, Missouri Care) explained that the letter provided an impetus for the physician's office to contact them if they saw an area of concern, such as a medical issue the member did not relate.

REFERRALS TO APPROPRIATE SERVICES

Figure 34 - Percentage of Case Records Containing Appropriate Provider & Service Referrals

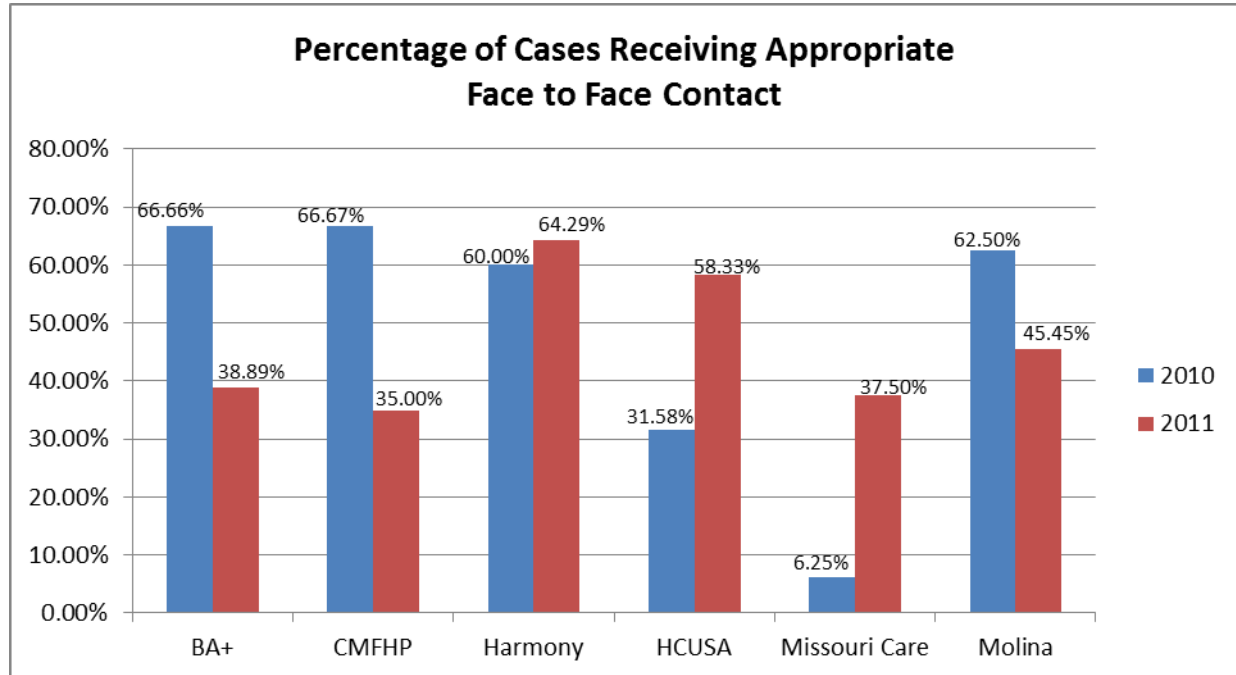


The standards concerning appropriate referrals require that the case manager assess member' needs and make referrals as appropriate.

1. The MCHP must ensure that members have referrals to all required providers, physicians and specialists.
 2. Case managers are required to discuss with members available services in the community and MCHP sponsored, such as transportation.
- Four of the MCHPs improved in 2011 in the area of making referrals for members (Harmony, HCUSA, Missouri Care, and Molina).
 - One MCHP (Harmony) made a significant improvement, but continued to reflect a lack of knowledge about available community resources, and MCHP providers other than network PCPs.
 - Two (BA+, CMFHP) MCHPs' records indicated fewer referrals in 2011 than in 2010.
 - During interviews at both MCHPs, case managers gave numerous examples of connecting members with resources, both through the MCHP and in the community. The decline may be a result of inadequate recording, but evidence that referrals were discussed with the member did not exist in the records reviewed.

FACE TO FACE CONTACTS

Figure 35 - Percentage of Cases Receiving Appropriate Face to Face Contacts



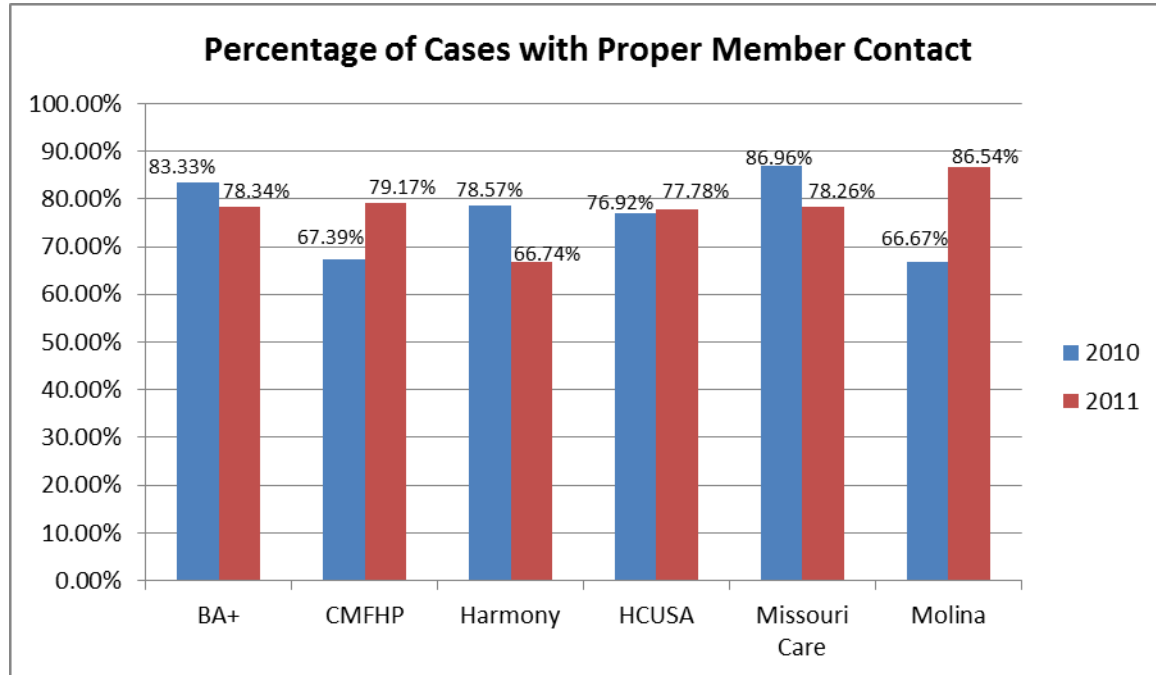
- The Managed Care contract contains standards that require specific face to face contacts for members in lead case management, members who are pregnant, and in other cases as deemed necessary.
 - Three MCHPs showed improvement in this area (Harmony, HCUSA, and Missouri Care) from the 2010 review.
 - Three MCHPs had a decrease in the number of cases where face to face contacts occurred (BA+, CMFHP, and Molina).
 - Even though there was some improvement in this area in 2011, the highest percentage of cases receiving required face to face contact was only 64.29%.
- One MCHP (Harmony) began using a nurse case manager housed in their St. Louis office who worked primarily in the field making home visits or meeting members in a setting they chose.
 - This case manager carried the cases of all pregnant women in Harmony's Missouri market. The cases reviewed indicated the ability to maintain contact with members throughout their pregnancy. The case manager was able to establish a strong working relationship with the members and provide services, both medical and other community-based referrals, directly meeting their needs.



- This model of case management, in the home or natural environment of the member, provided examples of a method that could overcome many barriers identified by MCHPs in the delivery of case management services.
- Case managers at four MCHPs (BA+, CMFHP, HCUSA, and Harmony) reported making face to face contacts themselves. With the exception of the OB case manager at Harmony, this was described as occurring “as needed” or “occasionally.”
 - They reported meeting members at physicians’ offices, or in another neutral setting, and are not routinely seeing members in their homes.
- Required face to face visits in lead case management are often completed by the local health department, or lead abatement staff. If a referral is received from the MCHP, these visits are occurring as required in most instances.
- Case notes indicate that the MCHP case managers ensure that the members obtain medical supplies and services as required when contracted agencies conduct the face to face contacts with members.
 - The MCHP case managers communicate with the contractors on a regular basis and obtain reports about members’ needs.

CONTACT WITH MEMBERS

Figure 36 - Percentage of Cases with Progress Notes and Required Contacts



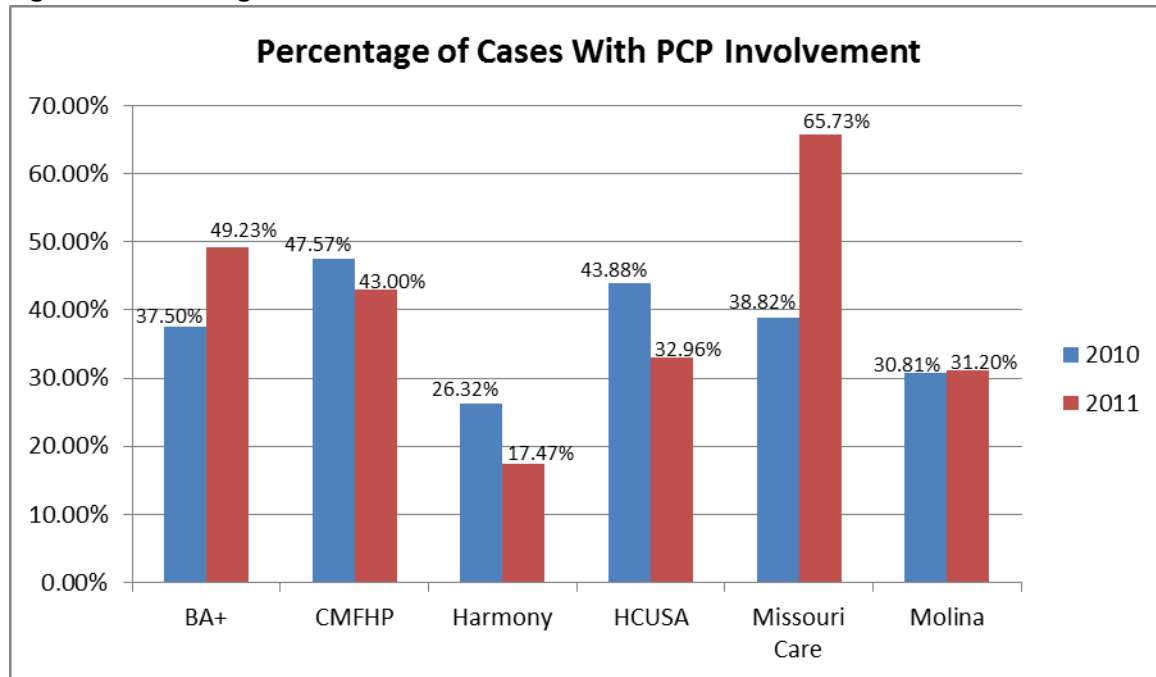
There are two standards used to assess maintenance of proper contact with members.

1. Case records are to contain progress notes updated at each contact or at least every thirty (30) days.
 2. Case managers are required to have at least three substantive contacts with a member prior to case closing, and these contacts are to be reflected in the progress notes.
 - Three MCHPs (CMFHP, HCUSA, and Molina) showed overall improvement in this area in 2011.
 - Two MCHPs (Missouri Care and BA+) improved in providing progress notes, but their overall rating decreased as the result of fewer cases with the required number of contacts.
 - One MCHP (Harmony) decreased in providing progress notes and required contacts.
- Progress notes are completed in the MCHPs' case management systems. The case managers report that the process for recording attempted and actual contacts with members, providers, or others involved with the member is easier than in the past.
 - Case Managers continue to report difficulty in maintaining engaged relationships with

members. They believe this is a barrier to having substantial contact with them.

PCP INVOLVEMENT

Figure 37 - Percentage of Cases Where PCP Involvement Occurred

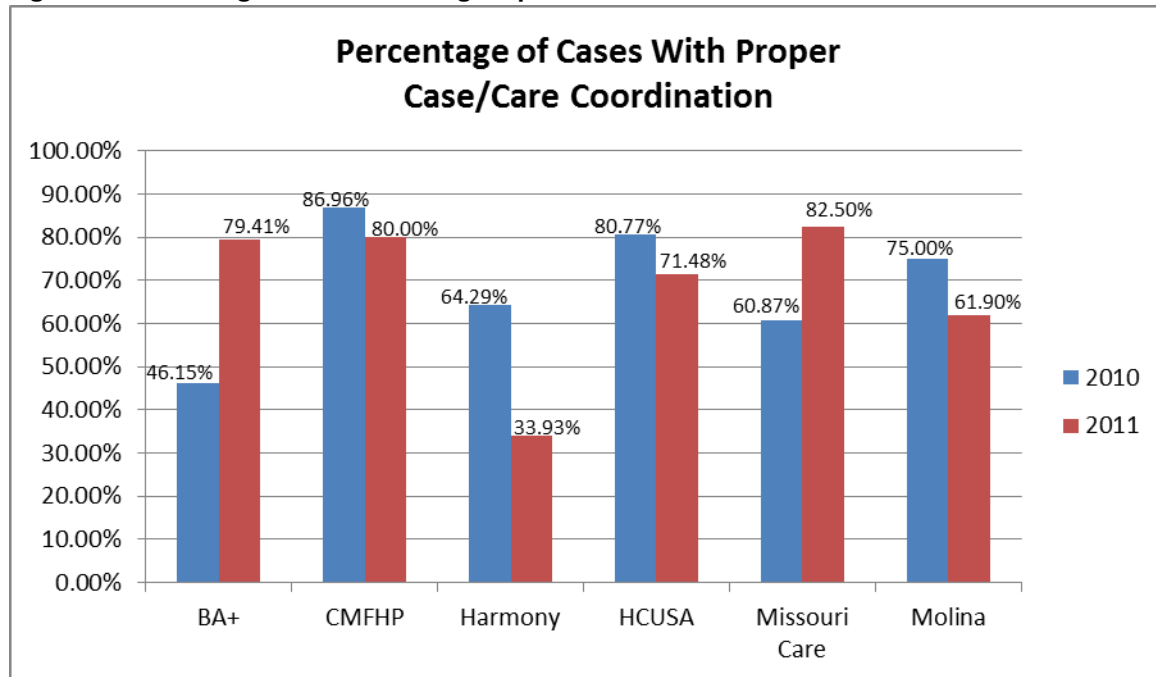


There are two standards used in measuring PCP involvement.

1. The case manager is to maintain contact with the member's PCP or primary physician.
 2. The case manager is to inform the PCP at case closing or when the MCHP is no longer providing case management services to the member.
- Two MCHPs (BA+ and Missouri Care) improved in developing these relationships and properly informing PCPs about case closing.
 - When cases close a letter is sent to the member. Cases are often closed due to loss of contact with the member. Very little follow-up occurs with the PCP or clinic of record.
 - None of the MCHPs is above the 70% range in meeting these requirements.

CASE/CARE COORDINATION

Figure 38 - Percentage of Cases Involving Proper Case/Care Coordination



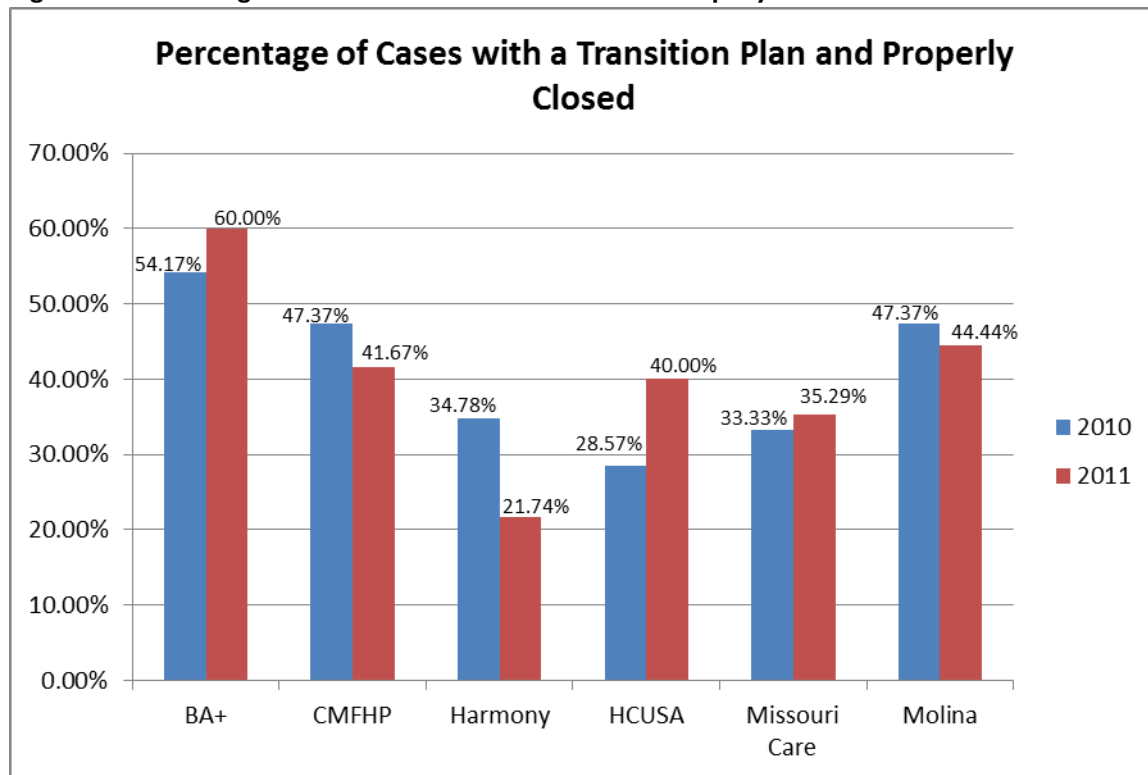
There are two standards used to assess the category of case/care coordination.

1. Case managers are to recognize the need for coordination of services with other providers involved with the members.
 2. Case managers are to ensure that the availability of behavioral health services is discussed with the member.
- Recognizing the need for care/case coordination.
 - Two MCHPs (BA+ and Missouri Care) improved in both areas in 2011.
 - The case managers clearly identified the need to report on efforts to contact home health providers, case managers from public health agencies, the Family Support Division or the Children's Division.
 - These case managers actively discussed the need for behavioral health services and made appropriate referrals.
 - These activities were captured in progress notes, and were not just a check box on an initial assessment tool.

- Two MCHPs (CMFHP and HCUSA) improved only in the area of care coordination in 2011.
 - Case managers failed to discuss the need for or availability of behavioral health services other than mentioning this during an initial assessment.
- Cases were reviewed that included assessment tools indicating a history of depression or other mental health issues. Behavioral health was not addressed with these members and no referrals were evident in the information available.
- In some instances care coordination was addressed.
 - When a case manager from another agency took the lead in ensuring that a member's needs were met this was seen in the progress notes. In some of these cases, the case managers made periodic contact with the family and ensured that there were no barriers to meeting the member's medical needs.
 - When this occurred the member appeared to benefit from the joint care management. By allowing one agency to take the lead, confusion for the member was avoided.
- The MCHPs successfully related meeting members' needs, whether they were medical or behavioral health. When they recognized the need for complex case management and coordination of care there was improvement in the processes used in meeting member needs.

TRANSITION AT CLOSING

Figure 39 - Percentage of Cases with a Transition Plan and Properly Closed



There are three standards included in appropriately terminating case management services.

1. The case manager must be assured that the member has achieved all stated care plan goals.
 2. A transition plan must be developed and the member informed.
 3. The case management services must ensure that the proper case closing criteria exist based on the type of case management received.
- Completing a transition plan:
 - Three MCHP's (BA+, HCUSA, and Missouri Care) showed improvement in completing transition plans.
 - The MCHP (BA+) with the highest percent of cases containing transition plans achieved a rate of 60%.

- The cases with no transition plan did often include “Unable to Contact” approved form letters to the member indicating potential case closure. There were no attachments or other information sent to the member, or to involved providers, explaining members’ options or plans for them to maintain their independence.
- Communicate the transition plan to members:
 - Members have a right to have all of their medical and other pertinent information transferred to a new provider when they change MCHPs, lose eligibility, or leave case management. Members are to be informed of these actions, and necessary follow-up as their case management is closing.
 - Language in approved closing letters stresses the importance of the member maintaining a relationship with the PCP, reminds the member of the availability of the MCHP’s nurse advice line, and lets the member know they have the ability to contact their case manager if necessary.
 - These letters are not to be construed as an actual transition plan, although they do provide useful information to the member.
- Cases remaining open for follow up services:
 - OB cases are required to remain open for 60 days after the baby’s birth, which coincides with the member’s continued eligibility for MO HealthNet Managed Care services.
 - One MCHP (Harmony) made an effort to see the member while they were in the hospital post-delivery. The case manager did discuss a type of transition plan with the member, and provided her contact information through closing. This did not allow for follow-up after the baby was home, or other issues, such as post-partum depression, which may not be evident at the time of the baby’s birth.

4.3 Observations for All MCHPs

QUALITY OF CARE

Introduction to Case Management

- When members are properly introduced to and engaged in case management the quality of service delivery improves. Case managers maintain contact and in some cases advocate for extraordinary services to meet members healthcare needs.
 - In 2010 and again in 2011 reviewers saw examples of case management services that provided referrals and communicated with the physicians or their staff regularly. These case managers assisted members in achieving their goals and stabilizing their health care conditions. They used MCHP sponsored services, linked members to community resources and ensured the outcome of improved member health.

Care Planning

- In cases opened for long periods of time the records included updated care plans. Case notes included references to issues that were resolved, new areas of concern, and why case management services continued for the member.

PCP Involvement

- In case records indicating contact with the physician's office, case notes reflected a depth of knowledge about the member that appears essential in providing comprehensive case management.
 - These cases included many contacts with the physician's nurse or nurse practitioners.
 - Physicians responded directly to inquiries and questions from the case managers.
 - When contacts occur the case notes indicate better and more complete service delivery.

Face to Face Contacts

- The Harmony OB Case Manager's model of service delivery, as described in an earlier section (Face to Face Contacts), greatly enhanced members' quality of care. The members receiving this service attended more prenatal visits and delivered healthier babies, as witnessed by data collected by the MCHP. This model should be considered by all MCHPs.

Opportunities for Improvement

Assessment

- Assessment tools are computer generated asking standardized questions. Case notes did not reflect a correlation between the information obtained in the assessment process and the direction of case management services.

Care Planning

- The care plans are often system generated directly from the assessment tool. Information provided did not reflect discussion with the member about their true needs, and how this process was going to positively impact the care or services offered to them.
- Informing the PCP, or including them in care plan development, was minimal.

Transition at Closing

- Completing and communicating a transition plan with members that provide direction and information was rarely observed.
- Informing the PCP and other providers when case management ceases, which is a component of effective transition planning, did not occur as required.

Lead Case Management

- It was observed that in the area of lead case management, member's quality of care was negatively affected.
- Twenty-six (26) cases opened as the result of a referral for elevated blood lead levels (EBLL) were reviewed.
 - Eighteen (18) of the lead case management cases raised concerns.

- Home visits or face to face contacts were not authorized or arranged as required.
- Few or no contacts were made with the member or the member's parent/guardian.
- These issues were noted in lead case management by three MCHP's (Harmony, Molina and HCUSA).

ACCESS TO CARE

Introduction to Case Management

- Access to care was enhanced in the cases where case managers actively worked with families. In a number of cases reviewers observed creative and relentless efforts to locate members. Some of the MCHPs utilize contractors who "drive by" a member's reported address to learn if the member is actually living there and/or to learn if forwarding information is available.

Percentage of Case Records Containing Appropriate Provider & Service Referrals

- Access is improved by case managers' efforts to obtain services, community based or by providers, which uniquely met members' needs.
 - A member needing on-going durable medical equipment never seemed to have an authorization in the system. The case manager closely followed the MCHP system, called the provider, and made sure that the supplies were delivered as needed.

Contact with Members

- Access was improved when case managers remained in contact with members receiving OB services. This ensured members' access to services such as a follow-up with their OB-GYN and a first visit to the pediatrician for the baby.

Opportunities for Improvement

Introduction to Case Management

- The listing from which the case review sample was pulled was “open and active cases in the 4th quarter of 2011.” Cases were received that were only open long enough to make three contacts and then closed. Although this was a small percentage of cases, the effort to locate members described by staff during the interview process is different than that reflected in these records.
- Consistent attempts to contact members, which are essential to ensuring good access to healthcare services, were not evident in a number of cases at each MCHP.

Contact with Members

- Case managers lost contact with members who had newborns. When they encounter problems contacting the members, case management services end and no transition plan is developed.

Face to Face Contacts

- Face to face contacts did not occur as required and were not contracted in many cases. The member did not receive services as needed, which negatively impacted health care outcomes.

Case/Care Coordination

- Lack of consistent case/care coordination practices was observed. This created some duplication of services, and failed to maximize MCHP resources.
- A lack of commitment to members who are difficult to locate or contact continues.

TIMELINESS OF CARE

PCP Involvement

When case managers are actively serving a member; fewer emergency department visits occur, members attend scheduled appointments, and assistance is provided to ensure that members see specialists in a timely fashion.

- When case management occurred throughout the OB cases reviewed, including the sixty (60) days postpartum, follow-up visits with the OB and initial pediatrician appointments for the newborn occurred within these time frames. These parents often enrolled their babies with the MCHP so ongoing preventive care could occur.

Transition at Closing

- Lack of effort to create transitional planning or follow-up with the member creates a situation where significant healthcare issues resurface due to unachieved goals.
 - Case Managers assert that after members' health care needs are met, the member loses interest in case management and no longer returns calls or responds to letters requesting they contact the case manager.
 - The case is then closed using the approved standard closing letter with no case specific plan included.

Care Planning and PCP Involvement

- Information sharing with PCP offices and sending a letter at case closing does not occur as required.
 - Case managers' lack of attention to this aspect of service delivery negatively impacts members' ability to obtain needed services in a timely manner.
 - Timeliness is greatly improved by ensuring that members, particularly children with special health care needs, obtain all necessary medical services with some oversight.

HEALTH PLAN OBSERVATIONS

Blue Advantage Plus

- Quality of care is improved when coordinated case management services occur with the goal of achieving quality outcomes.
 - Case managers identified 3 members, referred for issues related to special health care needs, as having EBLL.
 - These members received additional services to abate the elevated BLL problems.
 - This holistic approach benefits the members and ensures that all healthcare needs are addressed.

Children's Mercy Family Health Partners

- A member may have multiple case managers assigned to them. The MCHP assures that a “lead” case manager is assigned, but this practice appears to complicate the care planning and case management process. One example identified included the following:
 - A child is a pediatric diabetic and requires case management for pediatric related care. The family is also contacted by Disease Management for diabetic disease related teaching. A health coach is assigned to assist with supply needs and diet choices.
 - These three staff members all have access to progress notes to share co-case management information.
 - Confusion for the family appears throughout the record.
- CMFHP shared their Annual Case Management Member Survey Analysis. The comments and statistics were generally positive. One mother did state, however, that “she does not need to have another case manager contact her. She has never had difficulty getting services for her daughter.” The complex layering of services should be avoided when possible.

Harmony Health Plan

- The lead case management cases at Harmony Health Plan included the following issues:
 - A child was hospitalized with an EBLL of 50.9.
 - Additional medical problems were identified during the hospitalization.
 - No contact was ever made with the parent and no home visits were attempted.
 - The case manager's notes indicated they were unable to contact the

member and no services were provided.

- A lead referred case was closed with a note “Does not meet criteria for case management.”
 - One child was referred due to an elevated blood level of 42. It was closed as “Unable to Contact.” (UTC)
 - A child was diagnosed as having “lead poisoning.”
 - There were multiple other medical issues as the child had a gunshot wound resulting in an ostomy, was ADD, and had hearing loss.
 - In spite of recorded repeated calls from the mother a “UTC” letter was sent to the family.
 - There were no services or behavioral health referrals, and very few attempts to establish a relationship with the family or even maintain contact with them.
- Case managers are located in a remote location (with the exception of their OB Case Manager).
- These case managers did not demonstrate an essential understanding of the members they serve.
 - They discuss members in terms of the “market,” rather than individuals in need of guidance or services.
 - In 2010 the report stated that the remote case managers’ “Responses to questions do not reflect an intrinsic knowledge of the cultural or geographic idiosyncrasies that exist and are important to adequate member services. These case managers focus on the “St. Louis market” and have little knowledge of the remainder of the Managed Care Eastern Region.”
 - This disconnect from the community served continued to exist for the case managers located out of state. This fact negatively impacts members’ access to both healthcare and community service providers.
- Harmony Health Plan reported that they case managed 1% of their members, with a goal of 2-3%. Although there is no specific penetration rate established for case management, this is an essential component of the MO HealthNet Managed Care contract and should not arbitrarily be subject to a system that makes three superficial contacts and then closes the case due to “unable to contact.”

Health Care USA

- The lead cases included minimal or no contacts with members. Notification letters were sent to PCP offices. In one case the only contact made throughout were follow-up calls to this PCP office to check on progress regarding the BLL.
- Assessments and care plans were minimal in these cases.

Missouri Care

- Missouri Care had the highest percentage of case reviews with notification and involvement of the member's PCP. Case managers reported greater success in engaging PCPs, or their nurses, in responding to requests for input in care plan development. They send a letter and the care plan to the PCP, encourage members to tell the PCP they are involved in case management, and make additional contacts with physicians' offices. These efforts have created success in communicating with PCPs about member care.

Molina Health Care

- Lead case management cases at Molina Health Care were labeled as "care management" and very few contacts were made with the member or member's family. One case was particularly disturbing:
 - The child was referred due to an elevated blood lead level of 24.
 - The case was not opened because "No case management required after age 6, per state policy."
 - No attempts were made to contact the family.
 - There was no consideration of labeling the case as special health care needs and addressing the EBLL issue. The case was closed.

RECOMMENDATIONS FOR ALL CASE MANAGERS

1. Case managers should copy their own records when cases are requested for review. The case notes should include information indicating an understanding of the information collected through the assessment process or tool, and explain how this drives the services provided to the member.
2. The MCHPs should invest in a model ensuring that members receive the face-to-face

contacts required. This may be more direct contact with member, or better progress notes when a contracted entity is used.

3. Each MCHP must continue their commitment to finding “hard to locate members.” These are often the members who will truly benefit from the receipt of case management services.
4. Complex case management, care coordination and in some cases disease management, should be consistently defined.
5. All members requiring case management should have access to these services. Concerns remain about the number of cases actually opened for case management. Locating and identifying referred members, and engaging them in the case management process, is critical to meeting these members’ healthcare needs. Case managers must not only accept referrals from the variety of internal and external sources they describe, but intense follow-up should occur to locate and assess these members’ needs.

Lead Case Management

1. Lead Case Management must include active attempts to make a contact with the member or member’s family. A relationship should be established. Opening a case in the system, and checking on the member’s progress with the local health department, does not constitute case management services.
2. Renewed attention is required of the lead case management program. These cases include multiple children, and often include additional complex issues. Only routinely tracking reported BLL results through public health is a disservice to these members and their families.
3. When the MCHP routinely contracts with another agency to provide services information provided and results must be included in the progress notes.
4. The requirements of this program require these cases be tracked until the child’s EBLL is less than 10 or the child disenrolls. In these cases some type of follow up or referral is required. These cases must be properly managed.

6.0 Blue-Advantage Plus



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6.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Blue Advantage Plus supplied the following documentation for review:

- Improving PCP Follow-Up After Non-Emergent ER Visits
- Statewide Performance Improvement Project – Improving Oral Health

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on June 21, 2012 during the on-site review. Interviewees included the following:

Judy Brennan – Director State Programs BA+, Plan Administrator
Tee-Ka Johnson – Special Programs Coordinator
Shelly Bowen – Assistant Vice President, Quality Management

Interviewees shared information on the validation methods, study design, and findings of PIPs.

The following questions were discussed:

- What instruments were used for data collection?
- How were the accuracy, consistency, and validity assured?
- Why were the projects valid for continuation and used as PIPs for this project year?
- How are the findings relevant to the MO HealthNet Managed Care population?
- How was improvement analyzed?
- What are the conclusions about the effectiveness of the interventions analyzed?

FINDINGS

CLINICAL PIP – IMPROVING PCP FOLLOW-UP AFTER A NON-EMERGENT ER VISIT

Study Topic

The first PIP evaluated was the Improving PCP Follow-Up After a Non-Emergent ER visit. This project was submitted for the first time as a clinical performance improvement project. This clinical project focused on the importance of follow-up care with a primary care physician (PCP) after a member visits the emergency room, particularly for non-emergent reasons. Blue Advantage Plus (BA+) identified this as a problem after observing a trend in increasing emergency room utilization without a similar pattern in PCP utilization rates. The narrative information provided a strong argument for the health benefits that result from improved relationships between members and their providers particularly in the areas of care coordination and member education. The decision to implement this PIP was also based on a literature review that produced the following findings:

1. 85% of all ER visits are for non-emergent reasons; and
2. Compliance for follow-up with a PCP within thirty days after an ER visit should be at least 59%.

These studies also found that patients who had a relationship with their PCP made more appropriate use of the ER. The MCHP identified the populations that visit the ER most often were 1-6 year olds and females in the 21-44 year old age group. The MCHP designed this PIP with the focus on redirecting members back to their PCP, which will encourage them to establish a medical home. A medical home will allow the PCP to provide care coordination and improve the overall health and wellness of BA+ members. The PIP was designed to focus on members in the two groups identified as the most frequent users of the emergency room. The PIP exemplifies the commitment of BA+ to produce better and more productive health services that benefit their members. The information supporting the rationale for the study is fully integrated into the topic description on local issues and needs.

The study choice is supported as a relevant area of clinical care. How the study relates to issues relevant to BA+ members is well defined. The documentation gave a sound argument for not only impacting a key aspect of member care, but also related this choice to improving available services for MCHP members. The PIP narrative provided the information meeting the EQR protocol requirements for study topic choice. No members were excluded based on the need

for special health care services. Why members ages 1-6 and females ages 21-44 were specified is explained in the narrative.

Study Question

The study question submitted is:

“Will implementation of member outreach to the BA+ population (0-6 year olds and 21-44 year old females) after a non-emergent ER visit increase the 30 day follow-up rate with a PCP to 50%?”

This study question is focused, measureable, specific, and understandable. It clearly identifies the population and the reasons this PIP was formulated.

Study Indicators

The study indicators presented are clear, concise and measurable. Three indicators are presented. The indicators are based on increasing the thirty-day PCP follow-up rate after a BA+ member has generated a non-emergent ER visit. These indicators were implemented to measure the success of redirecting members to their medical home and to encourage members to develop a relationship with their PCP. Limitations and barriers, such as member tenure are discussed as they relate to the success of this project. A commitment to improving outcomes in this population is clearly stated. The study presented clearly defined indicators that were measurable and defensible. Information provided defined the numerators and denominators that would be used to calculate success. The focus of this study includes BA+ members only. The indicators measured the outcome – members obtaining a follow-up visit with the PCP within thirty (30) days of an ER event.

Study Population

The population included in the study is all MCHP members ages 0-6 and females ages 21-44 who had a non-emergent ER visit. The methods for referral to the program are clearly delineated and are inclusive in nature.

Sampling

No sampling was used to determine who would be included.

Study Design and Data Collection Procedures

The study design delineated the data sources to be utilized, how it will be collected, and the methodology used to analyze this data. Additional information received explained the methodology for data collection. Both the methods for quantitative and qualitative analysis were described. The CPT codes that will be used for evaluation and management were provided. This information is obtained using claims data in the FACETS system. The methodology for completing these data pulls was detailed in the narrative. The MCHP states that their system is designed to turn data into knowledge. The details of these sources were provided with adequate detail to produce confidence in their reliability and validity. The methodology remained constant across all time periods studied. The reports that will be generated for this PIP will be used to create and implement a program used to improve care, and the health and well-being of the members. Quarterly reports will be generated with information specific to this PIP. The baseline year was defined as 2008 and the PIP was set up to run through 2013 at a minimum. Each review included a quantitative and qualitative analysis. The data included information exclusive to MO HealthNet Managed Care members.

The study design specified the data collection and analysis plans and included a detailed definition regarding how methods were established creating internal monitoring of the members included in this program. A narrative explanation of how the qualitative and quantitative analysis will occur was found. An in-depth prospective data analysis plan was detailed in the documentation. Additional planning prescribing barrier impact is presented. The prospective data analysis plan describes a systematic method to analyze data and what the MCHP hopes the data will reveal. This plan provided information on how results would be presented and compared.

The project manager, and all individuals involved in this study, were included in the information provided. Roles and qualifications were included in sufficient detail.

Improvement Strategies

The interventions for the baseline year (2008) and subsequent years through 2011 were described in detail. Interventions included and ongoing are:

2008

- Welcome Call script modifications
- ER Case Management

2009

- ER Magnet Mailer

2010

- ER Case Management expansion
- Well-Aware – specific articles and information sharing

2011

- PCP Brochure
- ER Case Management expansion

Interventions, barriers, and opportunities for improvement were included. The description includes an explanation of the interventions that remain ongoing, those that were abandoned as non-productive, and the new interventions introduced in each measurement year. All current interventions for the study year 2011 were explained. Next steps, or plans for additional changes to enhance the PIP were included.

Data Analysis and Interpretation of Results

All interventions and analysis were discussed in relation to the outcomes achieved. This information was presented according to the data analysis plan presented. Each year's results and the impact of the associated interventions is examined. The results are presented in a clearly understandable table with a narrative discussion following. Although success was achieved, it has not yet met MCHP goals. Barriers and environmental factors influencing the outcomes achieved were presented. The MCHP provided methods to rectify these negative factors hoping to achieve continued success and to reach all desired goals. The positive influence of ER case management was presented. The MCHP indicated an on-going commitment to this process in their efforts to positively impact member behavior.

Influences on member behavior, including a system malfunction that lead to a slight decrease in the 2011 measurement year were explained. The data indicates initial and continued positive trends. The analysis information included planned improvements, and a commitment to maintaining current efforts that created the positive impact achieved to date.

Assessment of Improvement Process

A well-constructed interpretation of success and the planned follow-up activities are described. The plans for new and innovative interventions geared toward improved ER case management and tools to improve electronic notification regarding members using the emergency room were included. A new plan for maintaining previous improvement and continuing efforts to reach the MCHP goal is presented.

Conclusion

This PIP is considered to have the potential to reach a significant level of success demonstrating credible findings with continuation of planned interventions and the corresponding new data. The analysis of all interventions and outcomes was detailed and convincing. Barriers were addressed in a manner that positively impacted member services and member behavior. This is a successful PIP demonstrating creative interventions.

NON-CLINICAL PIP – IMPROVING ORAL HEALTH

Study Topic

The second PIP evaluated was the BA+ individualized approach to the Statewide PIP “Improving Oral Health.” This is a non-clinical project. The rationale presented included information related to the statewide PIP study topic decision, and the argument for addressing the Blue Advantage Plus population individually. The rationale presented was thorough and clearly based on the need to enhance the approach to improving oral health for all MO HealthNet members. The BA+ project, based on individualized interventions pertinent to its members was supported with MCHP specific data. The narrative information effectively made the argument that this non-clinical approach to a performance improvement project was focused on improving the key aspects of member services. The narrative related to BA+ members was well researched and supported.

Study Question

The study question for this project is:

“Will provider education and implementation of member-focused outreach to the BA+ population (2-20) on the importance of dental visits increase the ADV HEDIS rate by 3%?”

The study question is focused, includes a specific goal, and informs the reader of the intention of BA+'s interventions.

Study Indicators

The Annual Dental Visit HEDIS measure is the primary study indicator. Using this indicator will create consistent results across all MCHPs. This measure and its technical specifications were provided. It is strongly associated with an improved process of care. BA+ notes that the average length of time a member is enrolled in the MCHP is seven and one half (7 ½) months. HEDIS criteria require that members who are not continuously enrolled during the measurement year be excluded. This is an identified barrier to improvement for the MCHP. The MCHP specific information included the ADV HEDIS rate, 31.7%, for the baseline year, HEDIS 2010 (CY 2009). The goal for improvement is a 3% increase in the annual HEDIS rate. The indicators were constructed to focus on improving the process of care facilitating improved health care outcomes for members ages 2 through 20.

Study Population

The study population includes all BA+ members ages 2-20 meeting the HEDIS technical specifications for the Annual Dental Visit measure. The specifications were explained in detail.

Sampling

No true sampling was employed in this PIP.

Study Design and Data Collection Procedures

The study design clearly articulates the purpose and data requirements for the study. Administrative data will be collected and utilized to calculate annual dental visit rates. The manner in which this data is collected, and how it will be managed by the project director, is provided. BA+ submits this information to VIPs, the NCQA certified software used to calculate their HEDIS rate. The information provided ensured that all data in this system was valid and reliable. In addition to the normal measures to insure valid data, the MCHP uses a Quality Performance Analyst to review all data submitted to HEDIS for accuracy and completeness. Qualitative and quantitative analysis will occur in July of each year. It also identified all information to be submitted to ensure that all relevant claims and encounters were used in the

appropriate calculations. The narrative states that all members ages 2-20 with a claim or encounter with a dental practitioner, with specific CPT/ICD-9 codes will be included. It is evident that systems are in place to produce accurate data for all time periods studies. All necessary elements are referenced in the documentation included.

A comprehensive prospective data analysis plan was developed. This included a description of the Maritz software that will aid in determining statistical significance of all data presented. The narrative on data collection and management discusses how the analysis will occur who will be involved. As data becomes available it will be analyzed by the Project Director, with a comprehensive evaluation in June of each year. Plans for annual reviews and comparisons are described. This includes planning for a quantitative and qualitative analysis each July. Results are to be shared with the Quality Council and the BA+ Oversight Committee each fall.

All team members involved, including the project leader, their roles, and qualifications were provided in detail.

Improvement Strategies

Interventions for each year included:

2009

- WellAware Articles educating members on oral health issues (Member Newsletter), which is ongoing; and
- BA+ Customer Service (ongoing) – MCHP or subcontractor assistance in finding a dental provider within the network, as well as assistance with making appointments is available.

2010

- Reminder letters to any member who has not seen a dentist for preventive services in the last six months;
- Dental Webpage – A new section was developed on the member website providing articles on the importance of good oral health and information on how to find a dentist.
- WellAware Articles;
- Cooperation in the Head Start's Dental Home Initiative;
- New Member Packets including a flyer "improving You Oral Health";
- Improvements in information available in the member handbook;
- An article reminding Providers to ask parents to get a check-up for all children;
- Outreach to members and their families when going to their annual well child visit;
- Development and distribution of a provider toolkit.

2011

- Dental Reminder Letters
- Well Aware Articles
- BA+ and DentaQuest Collaboration including direct calls to all members who have not completed their annual dental visit.

This is a comprehensive list of interventions, with the focus for 2011 being a personal contact from the dental subcontractor to assist in obtaining the dental visit and education about the importance of visiting the dentist on a regular basis. The MCHP made a commitment to continue previous interventions that had a positive impact, and to continue updating these with new approaches until their goal is reached. This comprehensive strategy has proven beneficial. Barriers are identified. The MCHP does point out that each year's interventions are focused on efforts to overcome these barriers.

Data Analysis and Interpretation of Results

Data analysis, including the baseline rate, and the re-measurement rates, are included. A description of the barriers to success was provided. The findings for baseline year and two follow-up years are included. This was produced as discussed in the prospective data analysis plan. A detailed quantitative and qualitative analysis was provided in the narrative. The tables and charts included were informative and produced in a manner that provided clarification to the reviewer, and were supported by the narrative included.

The HEDIS Annual Dental Visit rate for BA+ improved from 31.7% to 40.92%, which exceeds their stated goal during the first remeasurement year (HEDIS 2011 – CY 2010). The MCHP recognized that prior to the PIP, they did not have strong interventions in place that promoted good oral health care. They assert that changing the interventions from two to eleven proved to be a favorable experience for BA+ members. There were new interventions introduced in calendar year 2011. The HEDIS 2012 (CY 2011) rate was 38.1%. This was a slight decrease over the previous year, yet continued the significant improvement over their original HEDIS ADV rate. The MCHP analyzed the issues that impacted the current HEDIS rate. These included:

- Incorrect mailing addresses;
- Knowledge deficit among parents regarding the importance of preventive dental care;
- Reminder Letter IT problem, which lead to incorrect addresses.

Corrective action for the IT issue has already occurred. Additional plans to overcome the other stated barriers were planned.

Assessment of Improvement Process

This study produced evidence of credible findings. The first re-measurement period included in the information presented included a detailed analysis of the impact the interventions had on member and provider behavior. A detailed barrier analysis was included. The second remeasurement year, which encountered several strategic problems, resulting in a decreased HEDIS rate, also included methods for resolving these issues. A cogent evaluation of the data presented was included. The discussion presented described the effectiveness of the interventions, and how all available resources were utilized by members, creating an overall positive outcome.

This PIP provided quantitative improvement in the process of care. BA+ directly related the improvements to the interventions employed with members and providers. Statistical significance testing was employed to support the findings. The analysis included a commitment to continue efforts to improve the rate of Annual Dental Visits, and methods to achieve this goal. Barriers were analyzed in detail, and new interventions will address these issues. Planned improvements were included.

The MCHP provided convincing evidence that their comprehensive approach to making the needed improvements had merit. They clearly exceeded the 3% goal set for this statewide initiative. BA+ planned to continue to implement new and creative interventions for improvement and to monitor these for their rate of success. This supports the analysis that this year's improvement was real improvement.

Conclusion

BA+ has a sound plan for continued improvement. They realize that with only one positive re-measurement period they cannot claim that they have achieved long-term sustained improvement. However, their approach produces high confidence that this PIP will continue to be successful when future interventions are implemented.

CONCLUSIONS



QUALITY OF CARE

These PIPs focused on creating quality services to members in both the clinical and non-clinical approaches. A quality approach to engaging members, educating members, maintaining member participation, and engaging providers was evident throughout the documentation provided for both PIPs. A hands-on approach to engaging members in creating a relationship with the PCP and developing a medical home, rather than a dependence on the emergency room, was an admirable clinical approach to improving the quality of care. Continued allocation of resources and process improvement were evident throughout the non-clinical PIP. In both projects BA+ sought to improve the quality of services, which has resulted in improved member care.

ACCESS TO CARE

Both Performance Improvement Projects submitted by BA+ had a focus that addressed improved access to health care services. The first PIP used a direct approach with ER case management to assist members in identifying their PCP and in making follow-up appointments within thirty days of an ER visit. In the non-clinical PIP efforts were made to ensure that members were aware of the necessity of regular dental care and how to obtain this care, in an effort to improve their overall quality healthcare. These values were evident in the efforts made in the non-clinical project. The attention to reminding members of available resources, such as transportation, enhanced member access and directly impacted a positive outcome. The MCHP made a concerted effort to improve access for members and availability of good healthcare in both projects.

TIMELINESS TO CARE

Both projects had a distinct focus on timely and adequate care. In the first PIP regarding timely and appropriate follow-up visits with a PCP within thirty days, after an ER non-emergent visit, BA+ seeks positive health outcomes including creating a relationship with that provider for the member. In the second PIP, regarding improving the rate of annual dental visits, there was attention to assisting the member in identifying a provider and obtaining an appointment to

assure that the services needed by the member were delivered. The focus of both projects was to ensure that timely care was available to members and to ensure that internal processes or other barriers did not hinder this outcome.

RECOMMENDATIONS

1. Continue to assess PIP activities during the project year to identify issues, such as a system malfunction that could negatively impact results.
2. Both of these PIPs were well-written and complete. Continue developing projects with this level of commitment to improving member services and healthcare outcomes.
3. Continue using the expanded written format in the information submitted for review to communicate the intentions, planning, and processes utilized in developing and implementing the PIPs.
4. Continue to utilize the Conducting Performance Improvement Project protocol to assist in the process of project development and reporting.

6.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for BA+. BA+ submitted the requested documents on or before the due date of February 20, 2012. The EQRO reviewed documentation between February 20, 2012 and June 15, 2012. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- Ernst & Young's NCQA HEDIS 2011 Compliance Audit Report
- Letters of communication between the EQRO and BA+
- BA+ policies pertaining to HEDIS 2011 rate calculation and reporting
- BA+ Information Services (IS) policies on disaster recovery
- BA+'s HEDIS implementation work plan and HEDIS committee agendas for 2011
- Data warehouse validation procedures for the CRMS software
- DB2 data warehouse models of the interim data warehouse

The following are the data files submitted by BA+ for review by the EQRO:

- ADV Denom_Numerator.txt
- ADV Enrollment.txt
- CIS Combo 3 Denom_Numerator.txt
- CIS Combo 3 Enrollment.txt
- FUH Denom_Numerator.txt
- FUH Enrollment.txt

INTERVIEWS

The EQRO conducted on-site interviews with BA+ staff responsible for overseeing the calculation of the HEDIS performance measures. The objective of the visit was to verify the data, methods, and processes behind the calculation of the three HEDIS 2011 performance measures. This included both manual and automatic processes of information collection, storing, analyzing, and reporting.

FINDINGS

BA+ used the Administrative Method for calculation of the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness and Annual Dental Visits measures; the Hybrid Method was used for the 2011 Childhood Immunizations Status Combination 3 measure. MCHP to MCHP comparisons of the rates for Childhood Immunizations Status, Follow-Up After Hospitalization for Mental Illness, and Annual Dental Visits were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The HEDIS 2011 combined rate for Annual Dental Visits reported by BA+ was 40.92%, comparable to the statewide rate for MCHPs (41.84%, $z = 0.17$; 95% CI: 35.69%, 46.15%; n.s.). This reported rate is **higher** than the rates reported by this MCHP in the 2007, 2008, 2009, and 2010 EQR reports (33.72%, 32.54%, 32.73%, and 31.69% respectively; see Table 21 and Figure 40).

The reported rate for BA+ for the HEDIS 2011 Childhood Immunizations Status (Combo 3) measure was 62.77%, which is **significantly higher** than the statewide rate for MCHPs (57.47%; $z = 0.87$, 95% CI: 57.83%, 67.72%; $p > .95$). This rate has not previously been audited by the EQRO, and thus no comparison data is available.

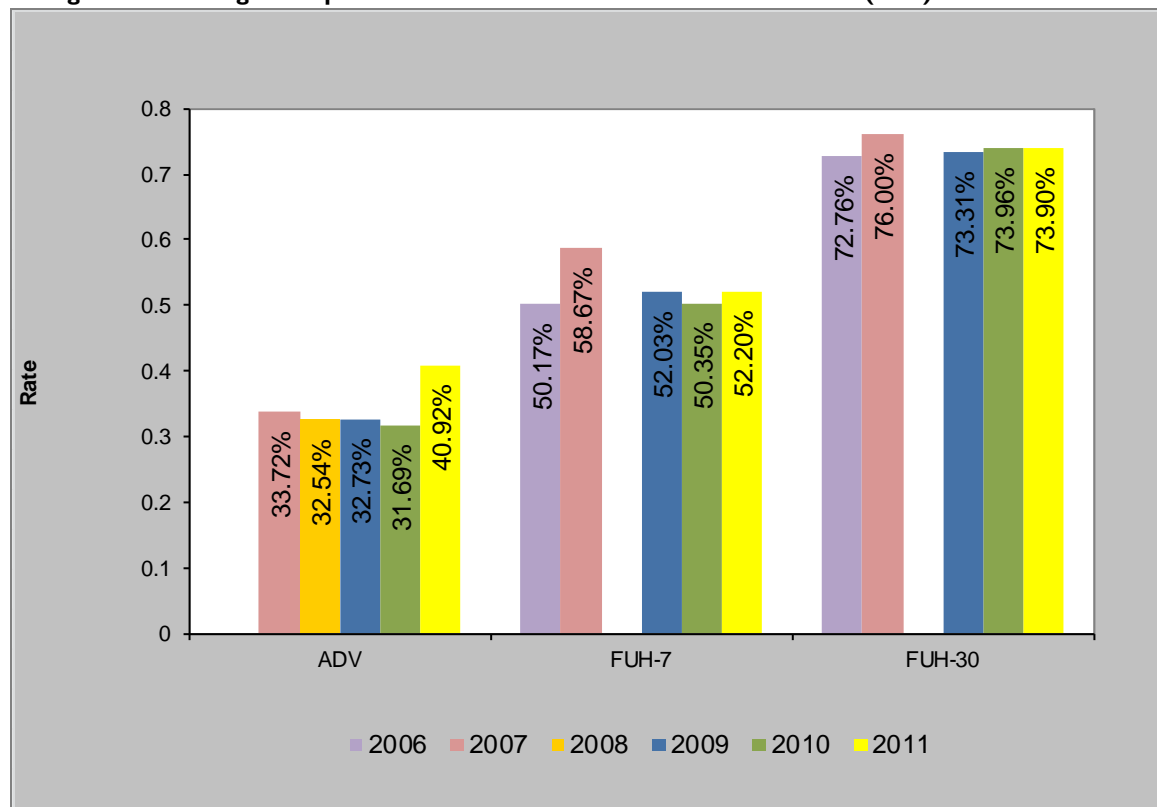
The 7-day reported rate for BA+ for the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure was 52.20%, which is **significantly higher** than the statewide rate for all MCHPs (45.61%; $z = 1.08$, 95% CI: 45.63%, 58.77%; $p > 0.95$). This rate is an **increase** from the rates reported in 2006 (50.17%) and 2010 (50.35%), but is still **below** the rates reported in 2007 (58.67%) and 2009 (52.03%; see Table 21 and Figure 40).

The HEDIS 2011 30-day rate for Follow-Up After Hospitalization for Mental Illness reported by BA+ was 73.90%, comparable to the statewide rate for MCHPs (66.22%, $z = 3.72$; 95% CI: 67.33%, 80.47%; n.s.). This reported rate is a slight **decrease** from the rates reported in the 2007 (76.00%) and 2010 (73.96%) review periods, but an **increase** over the rates reported by this MCHP in the 2006 and 2009 EQR reports (72.76% and 73.31% respectively; see Table 21 and Figure 40).

Table 21 – Reported Performance Measures Rates Across Audit Years (BA+)

Measure	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	HEDIS 2009 Rate	HEDIS 2010 Rate	HEDIS 2011 Rate
Annual Dental Visit (ADV)	NA	33.72%	32.54%	32.73%	31.69%	40.92%
Childhood Immunization Status, Combo 3 (CIS3)	NA	NA	NA	NA	NA	62.77%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	50.17%	58.67%	NA	52.03%	50.35%	52.20%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	72.76%	76.00%	NA	73.31%	73.96%	73.90%

Note: NA = the measure was not audited by the EQRO for that HEDIS reporting year

Figure 40 – Change in Reported Performance Measure Rates Over Time (BA+)

Sources: BHC, Inc. 2006-2011 External Quality Review Performance Measure Validation Reports

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the main report for activities, ratings, and comments related to the Validating Performance Measures Protocol Attachments.

DATA INTEGRATION AND CONTROL

BA+ used a NCQA-certified vendor application for calculation of rates for the HEDIS 2011 measures. The EQRO was given a demonstration of the data flow and integration mechanisms for external databases for these measures, and provided with a layout of the data structure of the internally-developed data warehouse for storing interim data. For the three measures calculated, BA+ was found to meet all criteria for producing complete and accurate data. There were no biases or errors found in the manner in which BA+ transferred data into the repository used for calculating the HEDIS 2011 measures of Childhood Immunizations Status, Follow-Up After Hospitalization for Mental Illness, and Annual Dental Visits.

DOCUMENTATION OF DATA AND PROCESSES

Data and processes used for the calculation of measures were adequate. BA+ met all criteria that applied for the three measures validated. BA+ did utilize statistical testing.

PROCESSES USED TO PRODUCE DENOMINATORS

BA+ met all criteria for the processes employed to produce the denominators of the performance measures validated. This involves the selection of eligible members for the services being measured. Denominators in the final data files were consistent with those reported on the DST for the three measures validated. All members were unique and the dates of birth ranges were valid.

There were 15,956 eligible members reported and validated for the denominator of the Annual Dental Visit measure.

A total of 1,348 eligible members were reported and validated for the Childhood Immunizations Status measure.

A total of 318 eligible members were reported and validated for the denominator of the Follow-Up After Hospitalization for Mental Illness measure.

PROCESSES USED TO PRODUCE NUMERATORS

Two of the three measures were calculated using the Administrative Method, one was calculated with the Hybrid Method. All three measures included the appropriate data ranges for the qualifying events (e.g., dental visits, immunizations, or follow-up visits) as specified by the HEDIS 2011 Technical Specifications. Appropriate procedures were followed for the sampling of records for medical record reviews.

BA+ reported a total of 6,529 administrative hits for the HEDIS 2011 Annual Dental Visit measure; 6,521 of these hits were validated by the EQRO. This resulted in a reported rate of 40.92% and a validated rate of 40.87%, an overestimate of 0.05%.

The Hybrid Method was used by BA+ to calculate HEDIS 2011 Childhood Immunizations Status measure, Combination 3. All 30 of the medical records requested were received, and all 30 were able to be validated by the EQRO. As a result, the medical record review validated 46 of the 46 hybrid hits reported. The MCHP reported 676 administrative hits; of these, the EQRO was able to validate 668. Based on the number of hits validated by the EQRO, the rate calculated was 62.04%, while the reported rate was 62.77%. This indicates an overestimate by the MCHP of 0.73%.

The number of administrative hits reported for the 7-day rate for the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure was 166; the EQRO found 165. This resulted in a reported rate of 52.20% and a validated rate of 51.98%, indicating a 0.31% overestimated bias.

The HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure 30-day rate showed 235 administrative hits; the EQRO found 232. This resulted in a reported rate of 73.90% and a validated rate of 72.96%. This represents a bias (overestimate) of 0.94% for this measure.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Childhood Immunizations Status measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure. BA+ was compliant with all specifications for sampling processes.

SUBMISSION OF MEASURES TO THE STATE

BA+ submitted the Data Submission Tool (DST) for all three measures validated. The DSTs were submitted to the SPHA (the Missouri Department of Health and Senior Services: DHSS) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS

As noted earlier, some bias was calculated in all three of the HEDIS 2011 measures evaluated. All three measures were slightly overestimated. However, the bias observed was minimal (less than 1% in each case). The rate validated for each measure fell within the 95% confidence interval reported by the MCHP for that measure.

Table 22 - Estimate of Bias in Reporting of BA+ HEDIS 2011 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	0.59%	Overestimate
Childhood Immunizations Status (Combination 3)	0.73%	Overestimate
Follow-Up After Hospitalization for Mental Illness (7-day)	0.31%	Overestimate
Follow-Up After Hospitalization for Mental Illness (30-day)	0.94%	Overestimate

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure. The rates for BA+ all three measure were overestimated. However, all fell within the confidence intervals reported by the MCHP.

Table 23 - Final Audit Rating for BA+ Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Substantially Compliant
Adolescent Well-Care Visits	Substantially Compliant
Follow-Up After Hospitalization for Mental Illness	Substantially Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCHP. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, or measures for which the submission data was incomplete and therefore could not be fully validated by the EQRO; Not Applicable = No Managed Care Members qualified for the measure.

CONCLUSIONS

BA+'s Annual Dental performance measure reported rate was consistent with the average for all MCHPs. The Childhood Immunizations Status rate was **significantly higher** than the average, and the Follow-Up After Hospitalization rate was consistent with or **significantly higher** than the average.

QUALITY OF CARE

BA+'s calculation of the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure was substantially complaint with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. BA+'s rates for this measure were comparable to or **significantly higher** than the average for all MCHPs. The MCHP's members are receiving the quality of care for this measure equal to or greater than the care delivered to all other Managed Care members. While both the 7-day and 30-day rates fell below the National Commercial Average for this measure, both rates were **higher** than the National Medicaid Average rate. The MCHP's members are receiving a quality

of care for this measure greater than the average National Medicaid member but below the average National Commercial member across the country.

Both the 7-day and 30-day rates were close to or higher than the rates reported by the MCHP during the 2010 measurement year. Although the 7-day rate did represent a slight **increase** over the HEDIS 2010 reported rate, the rates have not yet returned to the level previously seen from this MCHP in 2007.

ACCESS TO CARE

The Annual Dental Visit measure was substantially compliant with specifications; this measure is categorized as an Access/Availability of Care measure. Because only one visit is required for a positive “hit”, this measure effectively demonstrates the level of access to care that members are receiving. BA+’s rate for this measure was comparable to the average for all MCHPs.

This rate was a substantial **increase** from the rates reported in each of the previous four HEDIS reporting years (2007, 2008, 2009, and 2010), indicating an apparent **increase** in access to care for MCHPs members. BA+’s members are receiving the quality of care for this measure consistent with the level of care delivered to all other Managed Care members. This rate was however below the National Medicaid Average for this measure. This indicates that the MCHP’s members are receiving **lower** access to dental care than the average Medicaid member.

TIMELINESS OF CARE

The MCHP’s calculation of the HEDIS 2011 Childhood Immunizations Status measure was substantially compliant. This measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received. The MCHP’s reported rate for this measure was **significantly higher** than the average for all MCHPs. This rate has not previously been audited by the EQRO and therefore no data is available for a trend analysis.

The timeliness of care received by BA+ members for this measure is **higher** than the care delivered to all other Managed Care members. However, this rate was **lower** than both the National Medicaid and National Commercial averages for this measure. Thereby, the timeliness

of care received by this MCHP's members is **lower** than the average Medicaid or Commercial member across the nation.

RECOMMENDATIONS

1. BA+ should continue to utilize hybrid methods where HEDIS specifications recommend using the hybrid approach.
2. Continue work to conduct and document statistical comparisons on rates from year to year.
3. The Follow-Up After Hospitalization for Mental Illness Rate showed a slight **increase** over the previous audit year (2010) rate. The EQRO recommends that the MCHP monitor this rate and the strategies in place to see if a continued increase can be achieved.
4. The EQRO recommends that the MCHP continue to monitor trending in rates from year to year and responding to those trends by increasing efforts for those rates that do not **increase** (FUH30).
5. BA+ should review the strategies/initiatives in place currently that are effectively raising the ADV rate and continue such efforts to improve these services in the future.

6.3 MCHP Compliance with Managed Care Regulations

METHODS

Blue-Advantage Plus of Kansas City (BA+) was subject to a follow-up compliance audit during this on-site review. The content of this 2011 calendar year audit will include all components of the Quality Standards as defined in 42 CFR 438. Evaluation of these components included review of:

- Defined organizational structure with corresponding committee minutes
- Policies and Procedures
- Organizational protocols
- Print materials available to members and providers
- Report results
- Staff interviews

The Team utilized an administrative review tool which was developed based on the CMS Protocol Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient MCHPs (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Regulations (Compliance Protocol). The evaluation included review of MCHP's compliance with Access Standards, Structure and Operations Standards, and Measurement and Improvement Standards. Utilizing these tools, BA+ will be evaluated on the timeliness, access, and quality of care provided. This report will then incorporate a discussion of the MCHP's strengths and weaknesses with recommendations for improvement to enhance overall performance and compliance with standards.

The EQRO rating scale remains as it was during the last evaluation period.

M = Met

Documentation supports that all components were implemented, reviewed, revised, and/or further developed.

PM = Partially Met

Documentation supports some but not all components were present.

N = Not Met

No documentation found to substantiate this component.

N/A = Not Applicable.

Component is not applicable to the focus of the evaluation. N/A scores will be adjusted for the scoring denominators and numerators.

A summary for compliance for all evaluated Quality Standards is included in Table 24.

Table 24 - Comparison of BA+ Compliance Ratings for Compliance Review Years (2009, 2010, 2011)

Measure	2009	2010	2011
<i>Enrollee Rights and Protections</i>	100%	100%	100%
<i>Access and Availability</i>	82.35%	76.5%	82.35%
<i>Structure and Operations</i>	100%	100%	100%
<i>Measurement and Improvement</i>	100%	100%	100%
<i>Grievance Systems</i>	100%	61.1%	83.3%

Description of the Data:

The review of Quality Standards was completed using a Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations.

FINDINGS

Enrollee Rights and Protections

Enrollee Rights and Protections address 13 standards. For the 2011 review, BA+ was rated by the review team to have met all 13 standards. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2009 and 2010.

The rating for Enrollee Rights and Protections (100.0%), reflects Blue Advantages Plus' ability to have all policy and procedures submitted and approved by the SMA in a timely manner for the fifth consecutive year and have practices in place that reflect these policies. The MCHP provided evidence of their practice throughout the on-site review process. It appears that the MCHP is in compliance with all Managed Care contract regulations and federal requirements.

Blue Advantage Plus continues to exhibit commitment and enthusiasm toward ensuring that member rights and protections are in place. An atmosphere that empowered the Blue Advantage Plus (BA+) administrative and front line staff to meet all program requirements could be observed. The Annual Appraisal of Quality Improvement included an informative discussion of cross-departmental integration. It served to emphasize the corporate approach to management of BA+ and supported the management philosophy of BA+. Review of the meeting

minutes indicated the corporate involvement of the staff from BA+ and a support for the growth of BA+ programs.

Contacting members continues to be a struggle. However, case managers and member services staff make continued efforts to impact this in a positive way:

- A variety of continued contacts are made if initial attempts fail.
- Written information was provided in English or Spanish.
- If additional interpretive services were required, this was arranged for the member.
- They also report that several staff speaks Spanish.
- Translators and interpreters are available, and the BA+ staff often use AT & T linguists.

Access Standards

Access and Availability addresses 17 standards. For the 2011 review, BA+ was rated by the review team to have met 14 standards. This is an overall rating of 82.35% which is an improvement over the 2010 rating of 76.5%, but consistent with the 2009 rating of 82.35%.

Blue Advantage Plus submitted required policy and procedures to the SMA for their approval. However, in reviewing records and interviewing staff full evidence of assessments and treatment planning for members with special health care needs was not available. Blue Advantage Plus did improve in this area over the 2010 review as more information was found in the records reviewed. This improvement may be a result of the new case management software, which allows for more detailed notes, follow-up recording, and a reminder system for member contacts.

Blue Advantage Plus continues to have an adequate provider network available. Provider Relations staff actively recruit specialty medical providers. The MCHP reported that they continue to improve their relationships with providers. They are always anxious to recruit new providers. The MCHP reports that they continue to have a very stable network of providers, but continue to work on finding new resources. They recognize that having psychiatrists in

every county is a struggle.

Blue Advantage Plus does operate a providers' advisory committee that they utilize for review of internal policies and activities. Provider representatives meet with provider office staff monthly. They use these resources to obtain feedback on policy issues and to obtain input on pilot programs.

Physician complaints and member satisfaction surveys were used to trigger corrective actions and educational opportunities with providers. Provider Relations representatives contact any office that is found to be out of compliance with the after-hours access requirements. All member complaints regarding lack of after-hours access are forwarded to provider relations. The appropriate representative contacts the provider office and conducts educational sessions with staff. The Blue Advantage Plus requirements are reviewed and coaching is provided about what type of after-hours directions for members must be in place. Follow-up continues until all corrective action is taken. Additionally, representatives visit their assigned providers quarterly. The MCHP does monitor to assure that PCPs have open panels.

Blue Advantage Plus submitted required policy and procedures to the SMA for their approval. However, in reviewing records and interviewing staff full evidence of assessments and treatment planning for members with special health care needs was not available.

Structures and Operation Standards

The area of Structures and Operations addresses 10 standards. For the 2011 review, BA+ was rated by the review team to have met all 10 standards. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2009 and 2010. BA+ has completed all policy and procedural requirements of the SMA for the fifth consecutive year. During calendar year 2011, BA+ achieved NCQA Accreditation and all practice observed during the on-site review supported that the MCHP has made every effort to be compliant with both the Managed Care contract requirements and federal regulations.

Blue Advantage Plus provided regular oversight to all subcontractors. The MCHP meets with New Directions Behavioral Health, Doral Dental and MTM at regular Delegated Oversight Quality Meetings.

Blue Advantage Plus continued the use of Milliman Criteria, this approach has allowed nursing staff to make more informed medical management decisions. Using this tool in collaboration with provider discussions allowed for the most appropriate authorization of inpatient services. The Milliman Criteria provided a guide for medical practice. The MCHP also used specific practice guidelines from the American College of Obstetricians and Gynecologists (ACOG) and the Academy of Pediatrics. Practice guidelines are distributed by the Provider Relations Representatives. This group also assesses if the practice guidelines are in place and utilized. All providers were encouraged to recognize best practices and follow nationally accepted guidelines.

The credentialing policies and procedures continue to be compliant with SMA contract requirements and federal regulations. BA+ follows NCQA criteria for credentialing and site reviews are included. Medical record reviews are conducted in compliance with HEDIS requirements. A list of all providers and their credentialing dates is maintained by the MCHP to assure that re-credentialing is completed as required.

Measurement and Improvement

Measurement and Improvement addresses 12 standards. For the 2011 review, BA+ was rated by the review team to have met 11 standards; one standard was found to be Not Applicable. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2009 and 2010. Ratings for the Measurement and Improvement sections were found to be (100%) for the seventh consecutive year, which reflects that all required policy and practice meets the requirements of the Managed Care contract and the federal regulations.

The MCHP reports that its network includes over 1,600 physicians. It is experiencing fewer complaints each year from members. Blue Advantage Plus staff believes this is due to the longevity of the relationships with most of these providers. The MCHP employs a Physicians Advisory Committee and provides information and training prior to making policy and procedural changes. This group assists in communicating necessary changes within the provider community. Physician profiling occurs and incentives are in place through the MCHP's Quality Program. Quarterly audits are completed and communicated to all providers.

Blue Advantage Plus continues to ensure that providers use practice guidelines accepted by national organizations, as well as those based on local standards. The MCHP uses the Provider's Office Guide and provider newsletters to disseminate information about practice guidelines to the provider community.

Blue Advantage Plus submitted information to complete the Validation of Performance Measures. They continue to operate a health information system within the guidelines of that protocol. Performance Improvement Projects and Performance Measures were validated and in compliance with all State and Federal requirements. The details regarding these areas of validation can be reviewed within specific sections of this report.

Grievance Systems

Grievance Systems addresses 18 standards. For the 2011 review, BA+ was rated by the review team to have met 15 standards; three standards were rated as Partially Met. This is an overall rating of 83.3% compliance, which is **higher** than the rating received in 2010 (61.1%), but **significantly lower** than the 100% rating received in 2009.

Review of Grievance and Appeals Files

The EQRO reviewed grievance and appeals files while on-site at Blue-Advantage Plus of Kansas City on Wednesday, June 20, 2012. The EQRO Project Director, Amy McCurry Schwartz, read 30 files and completed an analysis tool for each file reviewed. These files were reviewed for compliance with Federal Regulations and the MCHP's State Contract. The table below summarizes the findings of this file review.

Table 25 – Compliance File Review, BA+

MCHP	# of records reviewed	# with issue	% with issues	% Correct
BA+	30	2	6.67%	93.33%

The specific issues identified by the Project Director in BA+'s files included the following:

- Letter to member contained confusing language, both "yes" and "no" appeal scenarios were included in the letter (1 file)

- The use of Explanation of Benefits letters in lieu of Notice of Action letters (the EOB did not contain the required language informing members of their right to continued benefits if they chose to appeal the MCHP's decision) (I file)
 - Per the recommendation of the EQRO during the prior year's on-site visit, the MCHP has stopped this practice and it was evident in the remaining files reviewed.

BA+ showed **significant improvement** in this area of the review, in 2010 the MCHP received a rating of 76.67% correct in the Grievance and Appeals File review in contrast to the 2011 rating of 93.33% correct.

Although not specifically attributable to this MCHP, the EQRO notes for the second consecutive year that the mandatory language required by the State of Missouri in all Notice of Action letters is considered confusing by the EQRO. The language contained in the clause related to the member's right to "Continuation of Services" and the requirement to list all legal aid offices in the State of Missouri and not the one specific to the member's address both serve to make the letter confusing.

State Inquiry Log review

The EQRO also reviewed each MCHP's response to any "inquiries" received by the SMA during the fourth quarter of Calendar year 2011 that pertained to a BA+ member. BA+ had a procedure in place for dealing with "State Inquiries", these are forwarded to the BA+ Plan Administrator and processed according to the Grievance/Appeal policy as required. For this review, four inquiries were received by the SMA during 4QCY11 for BA+ members. According to the MCHP:

- One of these inquiries resulted in the opening of an Appeal file, this file was reviewed by the EQRO and found to meet all requirements for timeliness and content.
- The MCHP was not able to supply any additional information for one case.

- The remaining two cases involved issues that were resolved by the State (one of those cases resulted in BA+ paying a claim).

CONCLUSIONS

BA+ continues to meet 100% of the written policy and procedural requirements of compliance with both the Managed Care contract and the federal regulations. Although not receiving 100%, the MCHP improved over the 2010 review year in both the Quality Assessment and Performance Improvement: Access Standards and Grievance System Standards.

It is evident to the reviewers that BA+ is focused on meeting member needs and that they sometimes go beyond the requirements of their contract in order to meet those needs.

QUALITY OF CARE

The quality of healthcare services produced through BA+ showed improvement in the area of Care Coordination during this review year. The EQRO was able to move closer to full validation of the MCHP's stated commitment to continuing quality improvement. However, the MCHP supplied case management files that still contained deficiencies in the areas of Care Coordination. These deficiencies included: 1) missing assessments; and 2) no evidence of completed treatment plans. Although the MCHP utilizes advisory groups that include community members and physicians, the EQRO did not find evidence that the perspective derived from these groups was utilized in the case management process.

ACCESS TO CARE

Blue Advantage Plus exhibits their commitment to access to care through their enhanced service initiatives. The MCHP improved in the area of Performance Measures and Performance Improvement Projects. The EQRO found many positive activities in these areas and notes that the MCHP's participation in community activities is very beneficial to members.

TIMELINESS OF CARE

Blue Advantage Plus demonstrates their commitment to ensure the timeliness of healthcare by the improvement projects they undertake and new initiatives started each year. The case managers state that they are aware of the need to assist members in obtaining timely health care and make every effort to intervene if they can assist. Again during this review year, no evidence was presented to the EQRO detailing the numbers of persons introduced to case management from these initiatives.

RECOMMENDATIONS

1. Continue development and use of products for predictive modeling and supporting empowerment of members to seek appropriate health interventions.
2. Continue efforts to improve behavioral health services and behavioral health case management practices, to ensure a coordinated approach to member care.
3. Ensure that case management records are inclusive of all pertinent information, particularly assessments and notes regarding follow-up and outcomes of care.
4. Track the number of members who enter case management through BA+ interventions/programs and the number who enter case management due to placement on a listing obtained from the SMA. This information would go a long way to show the success of the many quality initiatives that BA+ supports.

7.0 Children's Mercy Family Health Partners

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7.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Children's Mercy Family Health Partners supplied the following documentation for review:

- Improving Childhood Immunization Rates
- Statewide Performance Improvement Project – Improving Oral Health

The MCHP supplied data at the time of the on-site review providing additional information and data analysis. This included a final submission of statistical analysis.

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on June 22, 2012, during the on-site review, and included the following:

Jenny Hainey – Health Improvement Manager
Mike Cundiff – Information Systems Analyst

Interviewees discussed information on the validation methods, study design, and findings. The following questions were addressed:

- How were the accuracy, consistency, and validity assured?
- What findings were relevant to the MO HealthNet Managed Care population?
- How was improvement analyzed?
- What are the conclusions about the effectiveness of the interventions analyzed?

FINDINGS

CLINICAL PIP – IMPROVING CHILDHOOD IMMUNIZATION RATES

Study Topic

The first PIP evaluated was “Improving Childhood Immunization Rates.” The documentation provided a strong argument for choosing Improving Childhood Immunization Rates as a Performance Improvement Project topic. The topic justification included comparisons of national, state, and local data. The importance of the goal of improving immunization rates as a gateway to improved preventive care is clearly presented and explained. Improving the number of members obtaining immunizations is discussed. CMFHP cites research indicating that more information is needed to understand the factors that influence the decisions of parents regarding immunizing their children. They did provide their HEDIS rates for 2008 – 2011, which ranged from 68.6% in 2008 to a low of 60.1% in 2011. The rates for the first three years exceeded the Missouri State average. In 2011 CMFHP only ranked in the 25th percentile nationally (according to NCQA data). The statistics and information presented regarding changes looked at the HEDIS measure Childhood Immunization Status, Combo 2. The MCHP's stated goal is to improve this rate to 90%. The topic choice and rationale were supported by the review of local issues and comparisons to state and national trends. The MCHP does include proposals for interventions that they hope will positively impact these statistics.

The original hypothesis presented focuses on targeting non-adherent members for specific educational outreach. CMFHP had previously implemented educational efforts for members. In 2011 they added outreach mailings, automated calling and topic specific articles in newsletters to all eligible members. These efforts encouraged adherence to the immunization schedule.

Study Questions

The study is designed to answer the questions:

- 1) “Will increasing educational outreach by means of mailings, automated calling, and topic specific articles in newsletters to parents/guardians of members identified as non-adherent to the recommended immunization schedule increase access to preventative care services as demonstrated by an increase in the immunization rates for the intervention population by three percent?”

- 2) "Will increasing educational outreach by means of mailings, automated calls, and topic specific articles in newsletters to parents/guardians of all targeted eligible members result in an increase in access to preventative care services as demonstrated by an increase in the HEDIS CIS Combo 2 sub-measure rate to 63%, which is the 25th percentile (without NCQA rate adjustment) for this specific sub-measure?"

Although these questions are somewhat complex, they do focus on the adherent and non-adherent populations with the goal of increasing the number of children obtaining immunizations and comprehensive preventive healthcare. These questions were used in the previous PIP. However, at the time of the original review the PIP was not fully implemented. Interventions specific to the 2011 PIP were updated and enhanced.

Study Indicators

The study has objective, clearly defined and measurable indicators. The indicators, which will include an Intervention Population Indicator and the HEDIS Measure, are designed to present information that will determine if the additional immunization educational outreach (mailings, IVRS and newsletters) to the targeted eligible population is effective. The indicator looks at a change in health status and is focused on the issue of improving preventive care. Numerators and denominators for each measure are presented and clearly defined.

Study Population

The Intervention Study Population includes all children 2 years of age, as of the last day of the measurement period (12/31 of the measurement year). They are not required to be continuously eligible. The HEDIS Measure Study Population includes all children age 2 on the last day of the measurement period, who were continuously enrolled, without a gap of up to 45 days during the 12 months prior to the child's second birthday. These are clear and understandable. The measures include all pertinent children and do not exclude any part of the appropriate population.

Study Design and Data Collection Procedures

The study design is presented. It includes the data to be used – eligibility files and administrative claims from the preceding calendar year. These will be collected from the MCHP's claims data

system, which will be queried on a quarterly basis to measure claims activity throughout the year. The study data will identify members who did not receive or are due to receive recommended immunizations, which in turn presents the targeted population for each study question. The study design does identify the type of data to be used and its sources. The data fields and what they provide was described. Quarterly additions to the base files will occur. The claims data system is to be queried quarterly to measure activities throughout the year. HEDIS data for 2011 will be utilized to assess a mid-year baseline. HEDIS 2012 will provide for the first year's remeasurement period.

The narrative clearly defined the sources of data and a systematic approach to obtaining data that provided confidence that it would be valid and reliable. The instruments to be included, in addition to CMFHP's claims system, are the development of a spread sheet from the eligibility files. A prospective data analysis plan was presented in excellent detail. The approach exhibited in the study design provides evidence of the MCHP's commitment to improve access to preventive care for its members. Table 3 included in the narrative provides the 2011 rate of 60.01%. The MCHP uses this as a baseline. The stated goal for HEDIS 2012 is placed at 63%, for members appropriately immunized.

The information submitted did include the project manager, other study staff, their roles, and their qualifications. The narrative included a detailed prospective data analysis plan for each indicator.

Improvement Strategies

The interventions for 2011 specific to this study were:

1. Immunization Member Letters – Individualized letters were mailed to parents of children turning two years of age during the measurement period.
2. A partnership was developed with Pfizer implementing an immunization reminder program, which included reminder postcards and outbound telephone calls.
3. Updates of the public website ensured current immunization information was available.
4. A partnership with Merck was developed to provide educational training to MCHP education coordinators office efficiency strategies to reduce missed opportunities for immunizations. This education was offered to providers.

Activities initiated in 2010: Updated Member Handbook information regarding the importance of immunizations and the vaccine schedule according to age; refrigerator magnets; newsletter information; birthday cards; and EPSDT letter were continued, as these were seen as effective means of improving the immunization rates.

Data Analysis and Interpretation of Results

Data analysis was provided in detail. It looked at the total number of children turning 2 years of age who did not complete immunizations. It did follow CMFHP's stated data analysis plan. The analysis looked at the entire Combo 2 rate, as well as the numbers for members who received each of the six vaccines recommended. Numbers and percentages for each quarter were included. The narrative documented each intervention, including the actual number of children who received letters and outbound calls. The percentages compared to the total number of children in the study population were provided.

The HEDIS interim rates from HEDIS 2011 and 2012 were compared. This was done for each element of the Combo 2 measure, as well as for the total. There was an increase in each sub-measure with the exception of HiB, which had a decrease of 6.47%. The interim rates indicated an increase in the Combo 2 total of 1.28%. However, the actual HEDIS rates from 2011 to 2012 indicated a decrease of .73%. This decrease is not statistically significant, and an explanation is provided. They recognized that their intervention letters, which are member specific, started in June 2011, so HEDIS 2012 did not include enough time to evaluate results.

The MCHP believes the interventions currently in place, coupled with new interventions in place for 2012, will result in improved CIS Combo 2 HEDIS rates in 2013.

Assessment of Improvement Process

There is not enough data available to evaluate real and sustained improvement.

Conclusion

CMFHP's current efforts, and the information provided during the on-site review reveal a commitment to improved member services, and an understanding of the importance of the PIP

process. The information currently available leads to the conclusion that this is credible project that is capable of producing a project with high confidence in its results.

NON-CLINICAL PIP – IMPROVING ORAL HEALTH

Study Topic

The second PIP evaluated was the Children's Mercy Family Health Partners individualized approach to the Statewide PIP "Improving Oral Health." This is a non-clinical project. The decision to choose this study topic was supported by information provided regarding the MO HealthNet Managed Care Statewide PIP documentation. The study topic information presented includes information specific to the project that CMFHP began in 2008, prior to this becoming a statewide PIP. The MCHP incorporated information that was included in the statewide documentation. The rationale included specific information about the impact that good oral health has on general health. The connection between good and regular dental care and a member's overall physical health and well-being was explained. The MCHP provided the potential barriers to members obtaining the necessary dental care. Access to dental care is a primary ongoing challenge in the state and on a national level.

The study population was described including all members ages 2 – 20, and pregnant members. All of these members, particularly those without a dental visit within the past 12 months will be targeted. There are no exclusions, outside of the eligible population.

Study Question

The study question is:

"Will providing educational information about dental care and dental service through mailings, IVRS, and newsletters to CMFHP members from the ages of 2 – 20 increase the number of children accessing dental services and who receive an annual dental visit by 3% measured by HEDIS 2011 ADV rates (data from calendar year 2010) compared to HEDIS 2010 ADV rate (data from calendar year 2009)?"

CMFHP included a complex but thorough study question. It includes the study population, the goals of the project, and the outcome measures. There is nothing new provided in this section. The MCHP provided no updated PIP question that addresses current interventions or activities conducted in 2011.

Study Indicators

The study indicators are presented in a clear concise manner based on the HEDIS technical specifications. This is an administrative measure and the criteria for the HEDIS measure will be applied, including the continuous eligibility requirement. These are the same indicators outlined in the previous year of this PIP. The change will be based on each year's HEDIS rates, which would preclude any specificity over measurement year.

The numerator and denominator are included, with a stated goal of a 3% improvement in the first re-measurement year. There is no consideration of improvements identified in that measurement year or in calendar year 2011, which is the second re-measurement year. The narrative supports the stated belief that improvement in the measurement will reflect improvement in the process of care – the receipt of an annual dental examination.

Study Population

The study population definition explains that it will consist of all eligible members from the ages of 2 – 20 in the measurement year, which are the defined at-risk members based on the study topic. Earlier pregnant members were mentioned but are not pertinent to this study. In the description of the HEDIS technical specifications only the population of 2 – 20 year olds is referenced.

Sampling Methods

No sampling methods were utilized in this study.

Data Collection Procedures and Data Analysis Plan

The study design delineated the data to be collected, and describes all of the HEDIS data from 2010 and 2011. There is no update or references to new information from the quarterly HEDIS-like data pulls or discussion of how they will incorporate HEDIS 2012 data. The sources and methods of calculation are provided in detail. CMFHP will use all claims, and encounter data available. In addition, they will extract and load membership, practitioner and vendor data into the CRMS warehouse (MCHP data warehouse). Once this data is loaded it will be formatted and exported to all necessary files for evaluation. The Annual Dental Visit measure

utilizes data from the dental subcontractor, Advantica. Data is downloaded using an automated process that loads these figures into a data warehouse where they can be processed and measured. The study design addressed all necessary elements of data assessment. There is no mention of using calendar year 2011 data.

The study design did include a prospective data analysis plan. The 2010 HEDIS data will be the baseline measurement year. The 2011 data and beyond will provide the remeasurement data. Claims and eligibility data for the study population will be queried quarterly by the CMFHP information technology department. This data will be utilized to evaluate the effectiveness of the outreach interventions. The prospective data analysis plan addressed the baseline year 2009, and the re-measurement years 2010 and 2011. The prospective plan includes information on statistical significance testing.

CMFHP includes experienced and qualified staff in the data collection and analysis process for this project. Their names and qualifications were listed in an appendix to the documentation.

Improvement Strategies

CMFHP utilized a number of sources to implement the interventions during 2010. These included website additions and the use of social networking to communicate the need for improvement in this area. There was little discussion about these interventions.

The "Planned 2011 Interventions" include:

- Communication via provider bulletin regarding the prior authorization process
- Communication via provider bulletin of clinical practice guidelines
- Maintain dental benefit website with current articles: "Infant Oral Health – Early Stages"
- Publish provider newsletter covering multiple topics on dental health including a recap of the website article: "Infant Oral Health – Early Stages"

The MCHP plan explains that these interventions were chosen to enhance what occurred in 2010. The interventions are acceptable, and may enhance any previous success. However, they are not related to the Study Question presented, and there is no discussion about the need to move from a member-focused to a provider-focused strategy. The rationale for choosing these interventions was not presented. The MCHP did state they identified no barriers to using these interventions.

Data Analysis and Interpretation of Results

There was a complete analysis of the data, and the comparison between the baseline and each remeasurement year. Statistical significance testing was applied, and the improvement did indicate a positive increase using the chi squared method. All tables and graphs were clear and understandable. The HEDIS 2011 rate of 47.73% exceeded the goal of 46.66%. This is a definite improvement over the HEDIS 2010 rate of 45.30%. The HEDIS 2012 rate is 50.17%, which again demonstrates a statistically significant improvement, and exceeds the MCHP's stated goal of maintaining the 47.73% rate from HEDIS 2011. CMFHP's performance exceeds the state average in 2009, 2010, and 2011. The national average for calendar year 2011 (HEDIS 2012) is not yet published. In 2010 the National Medicaid Mean was 47.80%, which was only 0.06 % higher than the MCHP's rate. In completing the analysis the MCHP was able to determine that members' access to dental services was increased over the stated goal. Based on the data trends for the two remeasurement periods available, the MCHP believes the interventions utilized have been effective. The MCHP includes information on next steps to continue monitoring the HEDIS measure through interim rates, and to continue member education efforts through established interventions. (This is the first reference or update including HEDIS 2012.)

Assessment of the Improvement Process

CMFHP believes that the interventions implemented to date have demonstrated a significant improvement in member access to dental care, and member willingness to utilize this resource. The MCHP will continue reminding members to utilize available care through communications in their newsletter, on their website, and may implement other improvement activities. Targeted work with the dental subcontractor, Advantica, will also continue. The MCHP believes the intensive strategies which targeted both members and providers demonstrate that these improvement processes were effective and the results will be sustained.

CMFHP recognizes that they have exceeded the original project goals. They have incorporated the changes made into their organization work processes. Their efforts consistently demonstrated effective processes and improved access to dental services for children.

Conclusion

CMFHP individualized their approach and analysis to comply with the direction of the Statewide Performance Improvement Project. It did so in a manner that highlighted their approach to impacting the problem of under-utilization of this healthcare resource. As a result of the positive impact these interventions have had on this issue, CMFHP will continue both provider and member interventions. The MCHP stated the commitment to continue to monitor the HEDIS ADV rate through interim rate reviews, annual outcomes and comparison to the state and national benchmarks. This is a viable project. However, the narrative lacked continuity. There is a moderate degree of confidence in the approach due to these issues. The outcomes do demonstrate success and that is recognized.

CONCLUSIONS

QUALITY OF CARE

Quality services are provided in the most appropriate environment, and in a preventive manner, whenever possible. The two projects reported here embodied these values and sought to enhance the services available to the MCHP members. Quality health care is evident in the types of interventions used in these projects. The strong reliance on member education, and utilization of community resources to inform members about the services available to them, particularly with a focus on preventive care, is evidence of the MCHP's commitment to delivering quality services to members.

ACCESS TO CARE

The focus of both of the Performance Improvement Projects developed by CMFHP indicated a strong commitment to improving access to and knowledge about the preventive health care services available to members. In the first PIP, the MCHP provided information and training about the importance of accessing childhood immunizations. Although this PIP has only been implemented for one year, it is focused on an essential target of adequate childhood health services. The second project reviewed demonstrated that the MCHP took a comprehensive approach to member and provider education, and to improving access regarding the availability of dental care. Both projects enhanced members' knowledge about the availability of services

and enhanced their access to these services. The successful outcomes evidenced in the second PIP, provide clear evidence about CMFHP's commitment to better access to care. The education regarding accessing these important aspects of care, regular dental health and improved childhood immunizations, was effective in changing member behavior.

TIMELINESS OF CARE

Both PIPs concentrate on timely preventive care for children. The educational approach taken by these PIPs empowers families to make sound decisions that can lead to continued efforts to obtain timely preventive healthcare services on an ongoing basis. The PIPs focused on improving members' knowledge about the availability of timely healthcare.

RECOMMENDATIONS

1. Continue the work CMFHP is doing to perfect PIP methodology and data analysis. Ensure that results are reported with clarity and enough detail to allow for an appropriate evaluation of information submitted.
2. Ensure that data analysis reflects all of the information to be measured. Interpret this data, whether it reflects a successful intervention or not, and investigate any negative results to build upon this knowledge.
3. Ensure that PIP information presented includes original and updated information, throughout the documentation.

7.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for CMFHP. CMFHP submitted the requested documents on or before the due date of February 20, 2012. The EQRO reviewed documentation between February 20, 2012 and June 15, 2012. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- Children's Mercy Family Health Partners' information systems (IS) Policies and Procedures pertaining to HEDIS 2011 rate calculation
- Children's Mercy Family Health Partners' information services (IS) policies on disaster recovery
- Children's Mercy Family Health Partners' HEDIS committee agendas for 2011
- Children's Mercy Family Health Partners' HEDIS 2011 Training Manual for the medical record review process
- System edits for the claims management system

The following are the data files submitted by CMFHP for review by the EQRO:

- 2011_EQRO_ADV_Enrollment.txt
- 2011_EQRO_CIS_Enrollment_hybrid.txt
- 2011_EQRO_FUH_Enrollment.txt
- 2011_EQRO_ADV_NUM_DENOM.txt
- 2011_EQRO_CIS_NUM_DENOM.txt
- 2011_EQRO_FUH_NUM_DENOM.txt
- 2011_EQRO_File2_CIS_NUM_DENOM.txt
- 2011_EQRO_File3_CIS_MR.txt

INTERVIEWS

The EQRO conducted on-site interviews with CMFHP's staff that was responsible for calculating the HEDIS performance measures. The objective of the visit was to verify the data, methods and processes behind the calculation of the three HEDIS 2011 performance measures.

FINDINGS

CMFHP used the Administrative Method for calculation of the Annual Dental Visit and Follow-Up After Hospitalization for Mental Illness measures. The Hybrid Method was used for the calculation of the Childhood Immunizations Status measure. MCHP to MCHP comparisons of the rates of Follow-Up After Hospitalization for Mental Illness, Childhood Immunizations Status, and Annual Dental Visit measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) were reported.

The HEDIS 2011 combined rate for Annual Dental Visits reported by CMFHP was 47.74%, which is **significantly higher** than the statewide rate for all MCHPs (41.84%, $z = 1.22$; 95% CI: 42.51%, 52.97%; $p > .95$). This reported rate is also **higher** than the rates reported in 2007 (37.49%), 2008 (38.59%) 2009 (38.99%), and 2010 (45.30%; see Table 26 and **Error! Reference source not found.**) by this MCHP.

The rate for the HEDIS 2011 Childhood Immunizations Status, Combination 3 reported to the SMA and the State Public Health Agency (SPHA) by CMFHP was 54.26%. This was comparable to the statewide rate for MCHPs (57.47%; $z = -0.50$, 95% CI: 49.31%, 59.21%; n.s.). This rate was not previously audited by the EQRO and therefore no trend comparison data is available.

The 7-day reported rate for CMFHP for the 2011 HEDIS Follow-Up After Hospitalization for Mental Illness measure was 48.34%. This rate was comparable to the statewide rate for MCHPs (45.61%; $z = 0.61$, 95% CI: 41.77%, %; n.s.). This rate was a **decrease** from the rate reported in 2010 (51.82%) and was slightly lower than the rate reported in 2007 (48.50%), but has **increased** across HEDIS EQR review years over the rates of 45.15% reported in 2006 and 40.20% reported in 2009 (see Table 26 and **Error! Reference source not found.**).

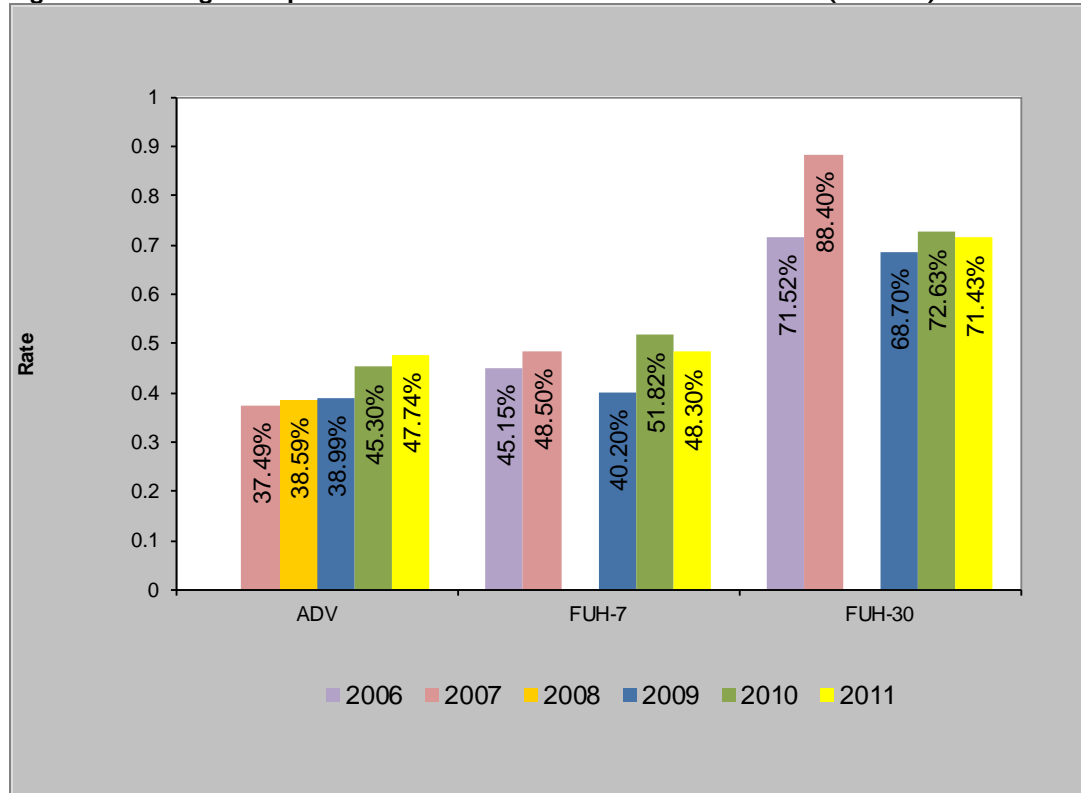
The 2011 HEDIS Follow-Up After Hospitalization for Mental Illness measure, 30-day rate reported for CMFHP was 71.43%. This rate was comparable to the statewide rate for MCHPs (66.22%; $z = 3.42$, 95% CI: 64.86%, 78.00%; n.s.). This rate was **higher** than the rate reported in the 2009 EQR audits (68.70%), but is **lower** than the levels seen in the 2006 (71.52%), 2007 (88.40%), and 2010 (72.63%) EQR audits (see Table 26 and **Error! Reference source not found.**).

Table 26 – Reported Performance Measures Rates Across Audit Years (CMFHP)

Measure	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	HEDIS 2009 Rate	HEDIS 2010 Rate	HEDIS 2011 Rate
Annual Dental Visit (ADV)	NA	37.49%	38.59%	38.99%	45.30%	47.74%
Childhood Immunizations Status, Combination 3 (CIS3)	NA	NA	NA	NA	NA	54.26%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	45.15%	48.50%	NA	40.20%	51.82%	48.34%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	71.52%	88.40%	NA	68.70%	72.63%	71.43%

Note: NA = the measure was not audited by the EQRO for that HEDIS reporting year

Figure 4I – Change in Reported Performance Measure Rates Over Time (CMFHP)



Source: BHC, Inc. 2006-2011 External Quality Review Performance Measure Validation Reports

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the main report for activities, ratings, and comments related to the CMS Protocol Attachments.

DATA INTEGRATION AND CONTROL

The information systems management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing and reporting. During the onsite review, the EQRO was provided with a demonstration of MedMeasures

software system. The accompanying MedCapture system was also demonstrated; this system allows for the calculation of the Hybrid hits from the medical record data inputs.

For all three measures, CMFHP was found to meet all criteria for producing complete and accurate data. There were no biases or errors found in the manner in which they transferred data into the repository used for calculating the HEDIS 2011 measures.

DOCUMENTATION OF DATA AND PROCESSES

Data and processes used for the calculation of measures were adequate. CMFHP met all criteria applicable for all three measures. CMFHP utilizes statistical testing and comparison of rates from year to year.

PROCESSES USED TO PRODUCE DENOMINATORS

CMFHP met all criteria for the processes employed to produce the denominators of all three performance measures. This involved the selection of eligible members for the services being measured. Age ranges, dates of enrollment, medical events, and continuous enrollment were programmed to include only those members who met HEDIS 2011 criteria.

The Annual Dental Visit denominator included 33,072 reported eligible members, all were validated by the EQRO.

For the denominator of the Adolescent Well-Care Visits measure a sample of 2,284 eligible members were reported and validated.

For the Follow-Up After Hospitalization for Mental Illness measure, a total of 602 eligible members were reported and validated by the EQRO.

PROCESSES USED TO PRODUCE NUMERATORS

All three measures included the appropriate data ranges for the qualifying events (e.g., immunizations, follow-up visits and dental visits) as specified by the HEDIS 2011 criteria.

Review of the administrative hits for the combined rate of the Annual Dental Visit measure validated 15,778 of the 15,788 hits found by the MCHP. The rate reported by the MCHP was 47.74%; the rate validated by the EQRO was 47.71%. The total estimated bias for the Annual Dental Visit measure was a 0.03% overestimate of the rate by the MCHP.

CMFHP used the Hybrid Method to calculate the HEDIS 2011 Childhood Immunizations Status measure. All 30 of the medical records requested were received, and all 30 were validated by the EQRO. As a result, the medical record review validated 70 of the 70 hybrid hits reported. The MCHP reported 153 administrative hits; of these, the EQRO was able to validate 150. Based on the number of hits validated by the EQRO, the rate calculated was 53.53%, while the reported rate was 54.26%. This yields an overestimate bias by the MCHP of 0.73%.

For the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure, the MCHP reported 291 administrative hits for the 7-day follow up rate. The EQRO found 289 hits. The rate reported by the MCHP was 48.34% and the rate calculated by the EQRO was 48.01%, with a bias of 0.33%: an overestimate by the MCHP in the reporting of the measure.

CMFHP reported 430 hits for the Follow-Up After Hospitalization for Mental Illness measure 30-day rate. The EQRO was able to validate all 430 hits. This resulted in both a reported rate and a validated rate of 71.43%, indicating no bias for this measure.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Adolescent Well-Care Visits measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure. CMFHP was compliant with all specifications for sampling processes.

SUBMISSION OF MEASURES TO THE STATE

CMFHP submitted the Data Submission Tool (DST) for each of the three measures validated. These DSTs were submitted to the SPHA (the Missouri Department of Health and Senior Services) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS

The following tables summarize the estimated bias in reporting each of the measures and the final validation findings. Table 27 shows no bias for the Adolescent Well-Care measure and only slight overestimates (inside the 95% confidence interval) for the Annual Dental Visit and Follow-Up After Hospitalization for Mental Illness measures.

Table 27 - Estimate of Bias in Reporting of CMFHP HEDIS 2011 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	0.05%	Overestimate
Childhood Immunizations Status (Combination 3)	0.73%	Overestimate
Follow-Up After Hospitalization for Mental Illness (7-day)	0.31%	Overestimate
Follow-Up After Hospitalization for Mental Illness (30-day)	No Bias	N/A

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet.

Table 28 shows the final audit findings for each measure. The Childhood Immunizations Status, Annual Dental Visit, and Follow-Up After Hospitalization for Mental Illness measures were all Substantially Compliant.

Table 28 - Final Audit Rating for CMFHP Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Substantially Compliant
Adolescent Well-Care Visits	Substantially Compliant
Follow-Up After Hospitalization for Mental Illness	Substantially Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCHP. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, or where incomplete data was submitted such that the EQRO could not fully validate the rate; Not Applicable = No Managed Care Members qualified for the measure.

CONCLUSIONS

Three rates were validated for the MCHP. CMFHP’s Annual Dental Visit rate was **significantly higher** than the average for all MCHPs. The other two rates (Follow-Up After Hospitalization for Mental Illness and Childhood Immunizations Status) were consistent with the average for all MCHPs.

QUALITY OF CARE

Children’s Mercy Family Health Partner’s calculation of the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. The MCHP’s reported rates were consistent with the overall MCHPs calculated rates. Therefore, CMFHPs’ members are receiving a quality of care for this measure equal to the care delivered to the average MO Health Net Managed Care member in both the 7-day and 30-day timeframes.

The reported 7-day and 30-day rates were both **higher** than the National Medicaid Rates but **lower** than the National Commercial Rates. Therefore, CMFHP is delivering a slightly **higher** level of quality than that received by the average Medicaid member, but slightly **lower** than that received by the average Commercial member across the nation.

Both the 7-day and 30-day rates reported in the HEDIS 2011 measurement year were **lower** than the last time this measure was validated (HEDIS 2010) which shows a **decrease** in the

quality of services provided to members over the past year.

ACCESS TO CARE

The calculated rate by CMFHP for the HEDIS 2011 Annual Dental Visit rate was substantially compliant with specifications; this measure is categorized as an Access/Availability of Care measure. Because only one visit is required for a positive “hit”, this measure effectively demonstrates the level of access to care that members are receiving.

CMFHP's reported rate for this measure was **significantly higher** than the average for all MCHPs; the rate has continued to rise over the rates reported by the MCHP in 2007, 2008, 2009, and 2010. CMFHP members are receiving a quality of care that is **higher** than the level of care delivered to the average Managed Care member.

The rate reported was only very slightly **lower** than the National Medicaid Average rate for this measure, showing that CMFHP members have close to the same level of access to dental care as the average Medicaid member across the nation.

TIMELINESS OF CARE

The MCHP's calculation of the HEDIS 2011 Childhood Immunizations Status measure was fully compliant. This measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received.

The MCHP's reported rate for this measure was comparable to the overall MCHPs calculated rate. This rate has not been previously audited by the EQRO and therefore no trend comparison data is available. CMHP members are receiving a timeliness of care equal to the care delivered to all other MCHP members.

This rate was **lower** than both the National Commercial Rate and the National Medicaid Rate, indicating that the timeliness of care received by CMFHPs' members for this measure is **lower** than the average Commercial member and the average Medicaid member across the nation.

RECOMMENDATIONS

1. Continue to conduct and document statistical comparisons on rates from year to year.
2. Continue to utilize the Hybrid methodology for calculating rates when allowed by the specifications.
3. The MCHP has experienced a continual **increase** in the Annual Dental Visit rate over the last four years. CMFHP should continue to support the strategies that have been implemented to improve this rate, as the positive results are evident.
4. The Follow-Up After Hospitalization for Mental Illness Rate showed a **decrease** in both the 7-day and 30-day rates from the previous audit year. The EQRO recommends that the MCHP monitor these trends and attempt to identify any further steps that can be taken to prevent further decline and reverse the downward trend.

7.3 MCHP Compliance with Managed Care Regulations

METHODS

Children's Mercy Family Health Partners (CMFHP) was subject to a followup compliance audit during this on-site review. The content of this 2011 calendar year audit will include all components of the Quality Standards as defined in 42 CFR 438. Evaluation of these components included review of:

- Defined organizational structure with corresponding committee minutes
- Policies and Procedures
- Organizational protocols
- Print materials available to members and providers
- Report results
- Staff interviews

The Team utilized an administrative review tool which was developed based on the CMS Protocol Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient MCHPs (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Regulations (Compliance Protocol). The evaluation included review of MCHP's compliance with Access Standards, Structure and Operations Standards, and Measurement and Improvement Standards. Utilizing these tools, CMFHP will be evaluated on the timeliness, access, and quality of care provided. This report will then incorporate a discussion of the MCHP's strengths and weaknesses with recommendations for improvement to enhance overall performance and compliance with standards.

The EQRO rating scale remains as it was during the last evaluation period.

M = Met

Documentation supports that all components were implemented, reviewed, revised, and/or further developed.

PM = Partially Met

Documentation supports some but not all components were present.

N = Not Met

No documentation found to substantiate this component.

N/A = Not Applicable.

Component is not applicable to the focus of the evaluation. N/A scores will be adjusted

for the scoring denominators and numerators.



A summary for compliance for all evaluated Quality Standards is included in Table 29.

Table 29 - Comparison of CMFHP Compliance Ratings for Compliance Review Years (2009, 2010, 2011)

Measure	2009	2010	2011
<i>Enrollee Rights and Protections</i>	100%	100%	100%
<i>Access and Availability</i>	100%	76.5%	76.5%
<i>Structure and Operations</i>	100%	100%	100%
<i>Measurement and Improvement</i>	100%	100%	90.90%
<i>Grievance Systems</i>	100%	94.4%	88.9%

Description of the Data:

The review of Quality Standards was completed using a Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations.

FINDINGS

Enrollee Rights and Protections

Enrollee Rights and Protections address 13 standards. For the 2011 review, CMFHP was rated by the review team to have met all 13 standards. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2009 and 2010.

The rating for Enrollee Rights and Protections (100.0%), reflects CMFHP's ability to have all policy and procedures submitted and approved by the SMA in a timely manner for the fifth consecutive year and have practices in place that reflect these policies. The MCHP provided evidence of their practice throughout the on-site review process. It appears that the MCHP is in compliance with all Managed Care contract regulations and federal requirements.

The staff at Children's Mercy Family Health Partners (CMFHP) continues to exhibit a strong commitment to ensuring that member rights are protected, and to solving member's health care problems. The MCHP utilizes interpreter services, pre-translated written materials, including the Member Handbook and all brochures, and a variety of methods for those members who

speak a language other than English. The MCHP provides alternatives to members who may have reading, vision, or hearing problems that enabled them to obtain required information about the MCHP or the services they can expect to receive.

Children's Mercy Family Health Partners continues to participate in community events including back-to-school fairs, work with area churches, the Chamber of Commerce, and events targeting the Latino and African American communities. They work with two groups specifically, El Central and CoHo. A Latino staff member attends many of these events to ensure appropriate information is shared with members about access to care.

Access Standards

Access and Availability addresses 17 standards. For the 2011 review, CMFHP was rated by the review team to have met 13 standards. This is an overall rating of 76.5%, which is consistent with the rating received in 2010, but significantly lower than the 100% rating received in 2009.

Children's Mercy Family Health Partners submitted required policy and procedures to the SMA for their approval. However, in reviewing records and interviewing staff full evidence of assessments and treatment planning for members was not available. These findings are detailed more specifically in the Special Project, Section 4 of this report. During the on-site review the commitment to good case management practice was evident during case management interviews. The MCHP exhibits a strong commitment to compliance with the Managed Care contract requirements and all federal regulations.

CMFHP continued to have a strong provider network throughout the Managed Care Regions. The MCHP has worked one-on-one with providers, including specialists who agreed to become panel members. Neurologists, outside of the MCHP network, ensure members have adequate access to these specialties when necessary. CMFHP continues to monitor their PCP availability and continues recruitment to ensure that adequate open panels are available.

The MCHP continues to use member satisfaction surveys and on-site reviews to monitor access standards. When deficiencies were identified they were dealt with in writing. Direct provider contact occurred where required. Re-audits occurred to ensure that improvement was sustained.

Structures and Operation Standards

The area of Structures and Operations addresses 10 standards. For the 2011 review, CMFHP was rated by the review team to have met all 10 standards. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2009 and 2010. The ratings for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the sixth year. The MCHP appears to be compliant with all policy and practice in this area.

CMFHP members have open access to specialists, with no referral from the PCP required. In some cases members receive assistance with referrals from the MCHP's case managers. When a member has a specific problem, and care coordination is needed between clinicians, this service is provided by the appropriate case manager.

During the 2011 Calendar Year, the MCHP became NCQA Accredited and continues to follow NCQA standards regarding credentialing. Re-credentialing is conducted every three years. Sanctions and quality are reviewed monthly. Current credentialing policies and procedures were approved by the MCHP oversight committee, and were approved by the SMA.

Measurement and Improvement

Measurement and Improvement addresses 12 standards. For the 2011 review, CMFHP was rated by the review team to have met 10 standards; one standard was found as "Partially Met"; and one standard was found to be Not Applicable. This is an overall rating of 90.90% compliance, which is lower than the 100% ratings received in 2009 and 2010. Although all required policy meets the requirements of the Managed Care contract and the federal regulations, the MCHP received significantly lower ratings in the area of Performance

Improvement Projects during the 2011 review (the specifics of these ratings can be found in Section 2.0 of this report).

CMFHP continues to be an active member of the Kansas City Quality Improvement Consortium (KCQIC) and utilized the practice guidelines developed and supported by that group. All clinical guidelines used are reviewed through the Clinical Criteria Committee prior to implementation. The MCHP utilizes Milliman Care Guidelines as a primary resource for pre-certifications, Utilization Review, and Care Managers for medical necessity determinations.

CMFHP continues to send providers a quarterly report card covering lead and EPSDT rates. This is used as an incentive to increase the screening rates. Solo-practice PCPs have the best rates in the MCHP.

CMFHP submitted information to complete the Validation of Performance Measures. They continue to operate a health information system within the guidelines of that protocol. Performance Measures were validated and in Compliance with all State and Federal requirements. The details regarding these areas of validation can be reviewed within specific sections of this report.

CMFHP did submit two Performance Improvement Projects (PIPs) for validation. It was noted that the MCHP utilized projects that had been started, and perfected these projects in an effort to improve services to members during the measurement year. These PIPs were well-constructed and provided adequate information for validation.

Grievance Systems

Grievance Systems addresses 18 standards. For the 2011 review, CMFHP was rated by the review team to have met 16 standards; two standards were rated as Partially Met. This is an overall rating of 88.9% compliance, which is **lower** than the rating received in 2010 (99.4%), and **significantly lower** than the 100% rating received in 2009.

Ratings for compliance with the Grievance Systems regulations (88.9%) indicate that the MCHP completed most of the requirements regarding policy and practice.

The EQRO reviewed grievance and appeals files while on-site at Children's Family Health Partners, in Kansas City, MO on Wednesday, June 20, 2012. The EQRO Project Director, Amy McCurry Schwartz, read 32 files and completed an analysis tool for each file reviewed. These files were reviewed for compliance with Federal Regulations and the MCHP's State Contract. The table below summarizes the findings of this file review.

Table 30 – Compliance File Review, CMFHP

MCHP	# of records reviewed	# with issue	% with issues	% Correct
CMFHP	32	6	18.75%	81.25%

The specific issues identified by the Project Director in CMFHP's files included the following:

- Notice of Action letter and Disposition letter contained different dates for receipt of Grievance (1 file)
- Disposition/Written notice letter was very poorly written, it did not meet the requirements of language level contained in the contract. A quote from the letter is as follows, "The provider that seen Celia stated that she informed your child the she..." (1 file)
- The disposition/written notice letter did not explain the reason for the resolution of the grievance. The letter merely stated, "The grievance is closed". (4 files)

CMFHP received **significantly lower** ratings in this area of the review, in 2010 the MCHP received a rating of 100% correct in the Grievance and Appeals File review in contrast to the 2011 rating of 81.25% correct.

Although not specifically attributable to this MCHP, it is noted that the mandatory language required by the State of Missouri in all Notice of Action letters is considered confusing by the EQRO. The language contained in the clause related to the member's right to "Continuation of Services" and the requirement to list all legal aid offices in the State of Missouri and not the one specific to the member's address both serve to make the letter confusing.

State Inquiry Log review

The EQRO also reviewed the MCHP's response to any "inquiries" received by the SMA during the fourth quarter of Calendar year 2011 that pertained to a CMFHP member. CMFHP did

not have a specific procedure in place for dealing with "State Inquiries", these inquiries were logged by the Customer Service staff in the MCHP's call logging system and upon request, the MCHP provided the EQRO with the notes for each of the State inquiries. For this review, seven inquiries were received by the SMA during 4QCY11 for CMFHP members. According to the MCHP:

- Three of these inquiries dealt with eligibility issues with the member, in all three the person seeking services was not an eligible member of CMFHP at the time of the service.
- Two of the inquiries dealt with members who were seeking out of network services, these services were provided by CMFHPs.
- One inquiry found that a CMFHP member was termed in error by the State. When this issue was brought to CMFHP's attention, the MCHP worked with the State to correct the member's status.
- The remaining case involved a series of calls regarding optical eligibility, all claims were paid as submitted.

After review of these inquiries, it was determined by the EQRO that these were correctly excluded from the Grievance and Appeals cases as submitted by the MCHP to the State for review.

CONCLUSIONS

During the 2011 review, the EQRO found that Children's Mercy Family Health Partners' strong commitment to meeting all policy, procedure, and practice areas of compliance with both the Managed Care contract requirements and the federal regulations to **decrease**. In past reviews, it has been noted that the MCHP exhibits a meticulous attention to meeting all the details of the regulations, submitting policy and procedural updates in a timely fashion, and utilizing the prior External Quality Reviews as a guideline for meeting required standards. Although the EQRO believes that CMFHP's had a strong commitment to meeting requirements in 2011, the MCHP did not produce the same results it has in past reviews.

Interviews with CMFHP reinforced the affect that organizational changes have had on the staff. Although, they demonstrated respect and dignity toward members, while meeting their

healthcare service needs efficiently and effectively, many of the details “fell through the cracks” during the 2011 year. Much of the documentation received in the area of Case Management record reviews did not support this commitment and the Performance Improvement Projects were not as successful as past submissions. CMFHP must ensure that the EQRO's auditors receive all requested information in order to report completely on what is occurring at the MCHP on a daily basis.

QUALITY OF CARE

CMFHP received significantly lower ratings in the areas of Quality Assessment and Improvement during this year's review. The EQRO was unable to validate many of the areas involving Care Coordination as the Case Management files received from the MCHP did not reflect Care Coordination. A commitment to quality that was conveyed during the on-site interviews, was not substantiated by the medical record review.

ACCESS TO CARE

Children's Mercy Family Health Partners demonstrates its commitment to ensuring access to care for members throughout their organization. The member services staff report:

- They supply information on available providers and their locations.
- They instruct members on utilization of the handbook to identify providers, including those that speak other languages or provide special services.
- They assist member in obtaining copies of their medical records.

The MCHP has also made many accommodations to ensure that members have access to the array of specialists they require to obtain quality healthcare services.

TIMELINESS OF CARE

The MCHP has ensured that the treatment of members and providers during the grievance and appeal process is of primary importance. During the file review of grievance and appeals, CMFHP significantly decreased in the percentage of accurate files observed. Although all of

their grievance/appeal responses meet timely requirements, the quality of these responses suffered greatly from the prior year's review.

RECOMMENDATIONS

1. Make every effort to supply the EQRO with all relevant information for every case file, grievance file, policy or procedure requested. The lack of information, that was verbally communicated to the reviewers explains many of CMFHP's **lower** rates for this year's review.
2. Continue to actively monitor providers and subcontractors and to develop corrective action initiatives when a problem is identified.
3. Continue a commitment to the Performance Improvement Project process, the lack of new interventions and the quality of the PIP write up were very disappointing.
4. Case Management and Care Coordination were issues for this year's review, evidence of treatment planning and assessments were not present in all requested case files, make every effort to assure these are occurring and supply complete files for review.



8.0 Harmony Health Plan of Missouri



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8.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Harmony Health Plan supplied the following documentation for review:

- Improving Asthma Management
- Statewide Performance Improvement Project – Improving Oral Health

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on June 27, 2012 during the on-site review, and included the following:

Dr. Debra Moss – Medical Director

Esther Morales – Vice President, Quality and Field Operations (Well Care, Inc.)

The interviewees shared information on the validation methods, study design, and findings.

Technical assistance regarding study design and presentation of findings had been provided by the EQRO and MO HealthNet staff during the previous year, and subsequently during telephone conference calls. The following questions were addressed during the on-site review:

- What were the findings?
- What was the intervention?
- Was the intervention effective?
- What does Harmony want to study or learn from their PIPs?

The PIPs submitted for validation included substantial information. Additional analysis occurred between the time of the original submission of information and the time of the on-site review.

The MCHP was instructed that they could submit updated information that included enhanced outcomes of the intervention at the on-site review. Additional clarifying written information was received on that date.

FINDINGS

CLINICAL PIP – IMPROVING ASTHMA MANAGEMENT

Study Topic

The first PIP evaluated was titled “Improving Asthma Management.” This study was considered clinical and focused on improving the screening and treatment compliance with the Clinical Practice Guidelines for Management of Asthma. Harmony identifies this topic as relevant for its members due to the prevalence of asthma in the region being served and in its membership. The goal of the study is to implement interventions that will demonstrate an increased utilization of asthma control medications and improved asthma management. Harmony did extensive research on the prevalence of asthma and asthma related conditions in the Eastern Missouri region and cited studies that identified the St. Louis area as one of the top ten worst cities to live in for those with asthma. It conducted a literature review of national, regional and local sources that allowed them to identify asthma management as a critical aspect of preventive health care for their members.

The MCHP did present a barrier analysis in this section, which they stated will provide a “baseline” for measurement. This included member and provider issues that the MCHP can impact with the correct approach. The thorough topic discussion provided convincing evidence that the goal is to improve screening and treatment of members with asthma.

Harmony recognized that their HEDIS score in this area is less than the tenth percentile and believe that with a commitment to the performance improvement process they can create a more developed program.

Study Question

The study question presented is:

“Will targeted MCHP interventions of member and provider asthma management education increase the appropriate use of prescribed asthma controller medications to treat members with persistent asthma and increase the HEDIS measurement to the 75th percentile?”

The question framed the content and intention of this study. The question includes a stated goal. The additional information presented did clarify the interventions or focus of the study.

Study Indicators

The study indicator, which is the HEDIS measure for asthma management, was presented, the numerator and denominator provided, and additional information included to ensure that there is a clear understanding about this HEDIS measure, and what it states about asthma management.

Study Population

The study population includes all members ages 5 – 64 who are diagnosed with persistent asthma. This is clearly stated. An explanation is provided regarding 2011 being the first year that included members ages 5-64. In previous years the ages included were members 5 – 50 years old. However, based on a discussion of the 2012 HEDIS technical specifications it is clear that this number was changed in the HEDIS specifications, and not arbitrarily.

Review of Sampling Methods

The documentation provided indicates that there was sampling for this study related to their provider intervention. “The MCHP reviewed, or plans to review, the entire population which includes 157 members.” A numerator and denominator are defined. The narrative provides information regarding identifying the provider population, and that the number of charts to review does not exceed the HEDIS tech spec requirement of 160 members for a review sample. This provides the rationale for reviewing all relevant charts. The chart review will include an assessment to ensure that the physician is meeting all required practice guidelines requiring treatment of asthma related issues.

Study Design and Data Collection Procedures

The documentation does present the beginning of a study design. Harmony intends to use data obtained through the HEDIS methodology for an administrative measure – Use of Appropriate Medications for Asthma. This data will come from claims and encounter data. The encounters that are likely to produce a diagnosis of asthma, including the CPT and diagnosis codes are presented. A systematic method is implied by the use of the HEDIS requirements. These planned pulls occur monthly and are published quarterly. This PIP was in process during calendar years 2009 and 2010. However, the HEDIS specifications for age changed from members 5-50 to members ages 5-64, with specific diagnoses excluded. The MCHP intends

to use HEDIS 2011 as a baseline year, and notes that the comparison is not entirely the same population. They do specify what data will be collected and the sources of the data.

The portion of the study that will include review of medical records is discussed. How these two approaches will be integrated into an analysis of the performance improvement approach is presented. The study design included did explain the method to be used to collect valid and reliable data for this population. They are using claims and encounter data, collected monthly to reflect any trends, so interventions can be adjusted if necessary. The systems to be used, and the software used to analyze data are presented. This provides confidence that the data collection process will be consistent and accurate throughout the project. All of this information was clarified in the PIP documentation presented at the time of the on-site review.

The newest version of this PIP also includes a prospective data analysis. This plan includes a separate explanation for the member intervention and the provider intervention (case record review). In the explanation regarding the plan for analyzing the provider information, the description regarding the numbers of records reviewed was confusing. Earlier the PIP documents stated that 157 records will be reviewed. In this section the MCHP states that it “reviewed 248 medical records of the 148 of the 157 requested...” These numbers do not coincide with the 157 records mentioned earlier in the information presented. In this section final results are also presented. The section is entitled “Data Analysis Plan,” yet in both the member and provider sections actual data is presented. This section continues to require clarification and should provide consistent information.

MCHP personnel involved in the PIP, including the team leader, and support team, are all identified. Their roles and qualifications are included.

Improvement Strategies

Planned interventions for calendar year 2011 include:

- HEDIS Education/Screening Program
- Referring all members with persistent asthma to Asthma Disease Management
- Development and initial distribution of enhanced 12 page member education asthma booklet for all members with persistent asthma
- Case Record Review – Provider focused

The member initiatives did not begin until July 1, 2011, according to the narrative information presented. The MCHP explains that the case record review is focused on identifying provider compliance with using the Asthma Clinical Coverage Guidelines. They believe that more members will be provided with correct and timely medication if the use of these guidelines is utilized when working with a member with asthma. This section states:

“The MCHP attempted to review the medical records of all 157 members identified with persistent asthma for provider compliance to the National clinical practice asthma guidelines. 14 members’ charts, totaling 245 charts were actually reviewed. Since the number of members identified was less than 160, no random sampling was required.”

It is unclear what this actually means. The numbers, again, conflict with figures provided in other sections of this report (Sampling Methods and Data Analysis Plan). Results were provided in this section. These results should be part of the data analysis section of the MCHP’s PIP submission. These results will be evaluated in that section of this report.

Although Harmony has outlined interventions that appear to have merit, the presentation of this information, particularly the provider intervention, is difficult to understand. Due to conflicting numbers, a complete evaluation of the process outlined cannot be completed.

Data Analysis and Interpretation of Results

The results of the interventions that were implemented were discussed in detail throughout the documentation presented. It was somewhat confusing and difficult to analyze. Harmony did present its interpretation of the results achieved through the end of the 2011 calendar year. The HEDIS measure regarding the use of appropriate controller drug prescriptions for persistent asthmatic decreased in their HEDIS 2012 outcomes. The MCHP points out that the definition of the ages included in this measure changed for beginning in 2011. Additionally, the planned interventions were not active until later in the measurement year. They believe with a full year of interventions they will be able to demonstrate positive results. The MCHP did provide numbers for the intervention of improving the number of members actively involved in the Disease Management program.

The physician chart review demonstrated that providers were not following the evidence based national guidelines for treating members with persistent asthma. Harmony was committed to using this process to ensure that providers acted in accordance with these guidelines. They pointed out that these guidelines have demonstrated that adherence reduced costs and

increased quality of life. They indicated a commitment to ensuring that the review process continued in an effort to move providers to compliance in this area.

Conclusion

Although the data available did not indicate significant improvement, the MCHP appeared to be genuinely invested in putting interventions in place that would enable the improvement needed to ensure that members were served. They put activities in place that improved involvement with members in an effort to impact this issue. The intervention focused on providers could have a significant impact on improving this measure. The chart reviews did reflect that in the cases where the clinical practice guidelines were followed emergency department visits decreased. The numbers were small and data comparisons were not available. The practice of this intensive chart review could make a significant impact on provider actions that truly improves services to members.

The documentation presented remained somewhat difficult to evaluate. However, it provided a great deal of information and detail about the MCHP's efforts to improve services to members with persistent asthma. It appears that if these efforts continued this PIP could result in better member services, improved HEDIS outcomes, and important changes in provider behavior.

NON-CLINICAL PIP – IMPROVING ORAL HEALTH

Study Topic

The second PIP evaluated was the MCHP individualized approach to the Statewide PIP “Improving Oral Health.” This is a non-clinical project. The decision to choose this study topic was supported by information provided regarding the MO HealthNet Managed Care Statewide PIP documentation. The rationale presented included the information pertinent to the decision to address this topic both as a statewide initiative and the importance to MCHP members. In the study topic narrative the MCHP related the need to improve oral health to its members. They were able to present information tying good oral health to good physical health. The study topic discussion included a barrier analysis. The analysis discussed the capacity of their new subcontractor, DentaQuest. They believe that this change alone will greatly improve access for their members, and will contribute to the overall success of their Performance Improvement Project. Harmony did mention that they changed dental subcontractors at the beginning of the year (January 1, 2011). They did not implement any initiatives for change prior to August 1,

2011.

Study Question

The study question presented was:

“Will providing the member and primary care provider interventions increase the number of members between the ages of 2 through 20 years old who receive an annual dental visit by 5% between HEDIS 2011 (data from calendar year 2010) and HEDIS 2012 (data from calendar year 2011)?

Harmony decided to set the goal for this PIP from the 3% for the statewide goal, to 5%.

Harmony intended to have a more profound impact on its members. The study question is uncomplicated and measureable. They point the reader to the intervention section to add specificity what will be measured.

Study Indicators

Harmony cited the HEDIS measure for annual dental visits as their primary indicator. It is the rate of MCHP members from the ages of 2 through 20 who have at least one dental visit as measured by the 2012 HEDIS total rate. The denominators and numerators were presented and explained. The claims and encounters figures information was included. The MCHP provided CPT, JCPC/CDTHCHCPCS, and ICD-9 codes to be used as identifiers. This is a HEDIS administrative measure. The information to be used as an indicator was presented thoroughly in a straightforward manner.

Population

Throughout the PIP the narrative recognizes the eligible population pertinent to this PIP: Children ages 2 – 20. There was no question regarding exclusions. Harmony intends to encourage all members to obtain their dental visits.

Sampling

There is no sampling for the Annual Dental Visit (ADV) measure. It is an administrative HEDIS measure.

In addition to the HEDIS measure, the MCHP intends to conduct a medical record review of pediatrician and family practice physicians to ensure that needed dental care is being discussed during office visits. Harmony used a random sample to identify the records to review. They planned to review 150 medical records. Their methodology chose every 25th member ID for members between the ages of 2 through 20. They conducted an over-sample of 250 member identifiers to ensure that enough records would be pulled where office visits occurred. This methodology and the rationale for the 150 records was explained to ensure that they had a statistically correct sample.

Study Design and Data Collection Procedures

The documentation presented specifies that the data to be collected for Indicator 1 is generally related to their HEDIS data for Annual Dental Visits using claims and encounter data. CPT codes are included, as is a description of the MCHP's HEDIS certified software. HEDIS certified software is employed to validate the data used. The denominator and numerator are defined. The MCHP intends to collect data monthly and report it quarterly. The HEDIS measure is reported annually.

The medical record review will be performed annually, but it is distributed throughout the calendar year.

The study design provided information in great detail. In January 2011 Harmony changed dental vendors. They did get baseline, 2010, and 2011 data from the previous subcontractor, Bridgeport Dental. The current subcontractor, DentaQuest, also generated data for 2011 and 2012.

The steps to ensure that consistent and accurate data collection occurred were provided. The methodology described provides confidence that the MCHP systematically collected valid and reliable data for the HEDIS indicator. The description of the method for obtaining medical record information was described in detail and also provides confidence that this was done in a manner that will lead credence to the study process.

The prospective data analysis plan explains that the member interventions will be evaluated by

demonstrating increases in the number of members completing dental visits during the measurement year. The success of provider interventions will be evaluated by demonstrating an increase in the number of practitioners who document the medical record indicating a discussion about oral health with the member. The methods for tracking both member and provider success was provided in detail.

Harmony Health Plan PIP team members, their roles, and responsibilities were included.

Improvement Strategies

Harmony provided a table that included Interventions for 2009 and 2010, the targeted population, and the barriers addressed. In 2011, no new interventions were started until November. All members not obtaining an annual dental visit were mailed a postcard/reminder. In addition MCHP staff attempted telephone contacts (up to 3) with members as a back-up to the postcards. The plan stated that mailings would occur in the 2nd and 3rd quarters of each calendar year. DentaQuest agreed to track all members without a dental visit, and to update listings of non-compliant members for the MCHP. This will enable the type of targeted intervention the MCHP developed. The postcard mailing only occurred one time in 2011. It was not clear if any follow-up telephone calls occurred.

The case record review process was discussed in detail in the section discussing the sampling methodology. However, it is not included in the section of the report discussing improvement strategies.

Data Analysis and Interpretation of Results

The HEDIS measure for annual dental visits decreased for 2012 (calendar year 2011). Harmony expressed their disappointment as they believed they had increased outreach to members.

The data analysis information presented did state that charts were reviewed during the entire 2011 year. There was no significant increase in finding documentation of physician referrals during the calendar year. They reported that no chart included a referral for a dental visit at a regular physician visit or during an acute event visit. In two cases the physician noted “multiple carries, but did not note a dental referral.” County health clinic records did consistently document dental visit referrals with well child exams. Although actual data was not presented

the narrative reflected that “it was disappointing to observe that the FQHC’s and another clinic that had dental services on site had among the lowest dental referral rates of all providers.” The data presented indicated that 36% of all medical records reviewed indicated that any dental information was presented to members. The MCHP concluded that “additional education of providers is necessary” regarding the importance of addressing the need for good oral health care.

Assessing real or sustained improvement was not possible, as the current strategies were not in place for enough time to make a valid evaluation of these aspects of the PIP.

Conclusion

Harmony made a serious effort to improve their approach to ensuring that Annual Dental Visits occurred for their members at the end of 2011. However, the calendar year as a whole saw few efforts from the MCHP. The PIP included extensive planning and expansion for 2012. This indicates that the MCHP intended to continue their efforts to educate both members and providers about the importance of good oral health care. The MCHP did not detail any consequences for providers who fail to include dental referrals in their discussions with members. They did propose some type of incentive for providers who are found in compliance with this requirement. This was not yet implemented at the end of 2011.

CONCLUSIONS

QUALITY OF CARE

Both PIPs are designed to improve the quality of services to members. Both PIPs sought to address and improve critical areas of care where deficiencies had occurred in previous years. They established strong goals for the success of their PIPs hoping to significantly improve the quality of care the members involved received. These PIPs had not yet achieved success, but the MCHP recognized the need to ensure that the quality of care available to members is an essential component of their role as health service providers.

ACCESS TO CARE

The non-clinical dental care PIP recognized that access to care was critical for members. Harmony contracted with a new dental vendor at the beginning of 2011 in an effort to expand the network of providers to members. This action alone did not achieve the results they sought. If PIP interventions would have been in place earlier in the year (contacting members by mailings and telephonic follow-up) members' knowledge about this improved access may have been expanded. It is apparent that the late start date of the intervention negatively affected the outcome. The clinical PIP might have created a positive effect regarding better access to care for members with asthma. By engaging more members in the Disease Management process they would receive education and information about the services available. This PIP had not reached a level of maturity where a valid assessment of their efforts existed.

TIMELINESS OF CARE

Timeliness of care could have been a positive outcome for each of these PIPs. The focus of the current projects presented indicated an understanding of the importance of this aspect of member care. These PIPs are both on the right track to address issues of timeliness, and it is a stated focus of the MCHP. The effort to use the performance improvement process as not only a study, but as a guide for creating a more effective environment for communicating with and serving members was just beginning at the end of 2011.

RECOMMENDATIONS

1. Harmony was provided detailed technical assistance about the requirements of developing meaningful and beneficial Performance Improvement Projects. They were given the opportunity to completely rewrite their projects throughout 2011. The final PIP documentation received at the time of the on-site review reflected a MCHP that took previous recommendations seriously and implemented many of them. Use of continued technical assistance would benefit their development.
2. The development of Performance Improvement Projects should be taken seriously. The federal protocols state that the purpose of the PIP process is to assess and improve processes, and outcomes of care. To achieve real improvements in care and for reviewers or the State Agency to have confidence in the reported outcomes, the PIP

- must be designed, conducted, and reported in a methodologically sound manner. The latest version of both PIPs reflected an improved understanding of this aspect of MCHP activities. Continuing this growth would be beneficial.
3. The interventions of a PIP should be focused and measurable. The interventions should include activities that are related to the issues the MCHP is attempting to improve. They should be concrete, and reflect new attempts at problem solving. These interventions should be specifically designed to improve the performance of the MCHP with the ultimate goal of improving health care or services to members. The interventions presented in the two PIPs reviewed met these requirements. Time did not permit an analysis of the outcomes that might have been achieved.
 4. The MCHP should recognize that an important aspect of the PIP process is creating new methods of improving services or member behavior that can then be incorporated into regular organizational activities.
 5. Harmony should include an assessment of how the interventions used in its PIPs contributed to its success. If interventions were not successful, this should be assessed frankly, with alternative proposed activities for future PIPs. The prior years' results should not be ignored because they were undesirable or because of a new subcontractor relationship. The PIPs presented for 2011 were improved. Continued work in this area would ensure that the PIP process was used effectively.

8.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Harmony. Harmony submitted the requested documents on or before the due date of February 20, 2012. The EQRO reviewed documentation between February 16, 2012 and June 15, 2012. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The NCQA RoadMap submitted by Harmony for the HEDIS 2011 data reporting year
- HealthCareData Company's NCQA HEDIS Compliance Audit Report for HEDIS 2011
- Harmony's information systems (IS) Policies and Procedures pertaining to HEDIS 2011 rate calculation
- Harmony's information services (IS) policies on disaster recovery
- Harmony's HEDIS committee agendas for 2011
- Harmony's HEDIS 2011 Training Manual for the medical record review process

The following are the data files submitted by Harmony for review by the EQRO:

- Tab_04 WellCare_ADV_File1.txt
- Tab_04 WellCare_cis_File1.txt
- Tab_04 WellCare_FUH_File1.txt
- Tab_05 WellCare_ADV_File2.txt
- Tab_05 WellCare_cis_File2.txt
- Tab_05 WellCare_FUH_File2.txt
- Tab_06 WellCare_cis_File3.txt

INTERVIEWS

The EQRO conducted on-site interviews Harmony staff via teleconference and on-site in St. Louis, MO on Tuesday, June 26, 2012.

FINDINGS

Harmony calculated the Annual Dental Visit and the Follow-Up After Hospitalization for Mental Illness measures using the administrative method. The Childhood Immunizations Status measure was calculated using the hybrid method. MCHP to MCHP comparisons of the rates of the three measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The HEDIS 2011 combined rate for Annual Dental Visits reported by Harmony was 28.44%, which is **significantly lower** than the statewide rate for MCHPs (41.84%, $z = -1.74$; 95% CI: 23.22%, 33.67%; $p < .05$). However, this rate has continued to rise to levels **higher** than those reported by the MCHP in 2008, 2009, and 2010 (16.94%, 20.68%, and 28.13% respectively; see Table 31 and Figure 42).

Harmony's reported rate for the HEDIS 2011 Childhood Immunizations Status measure reported to the SMA and the State Public Health Agency (SPHA) was 47.93%. This was **significantly lower** than the statewide rate for MCHPs (57.47%; $z = -1.53$ 95% CI: 42.98%, 52.88%; $p < .05$). This is the first year the Childhood Immunizations Status (Combination 3) measure has been audited by the EQRO and therefore no comparison data is available.

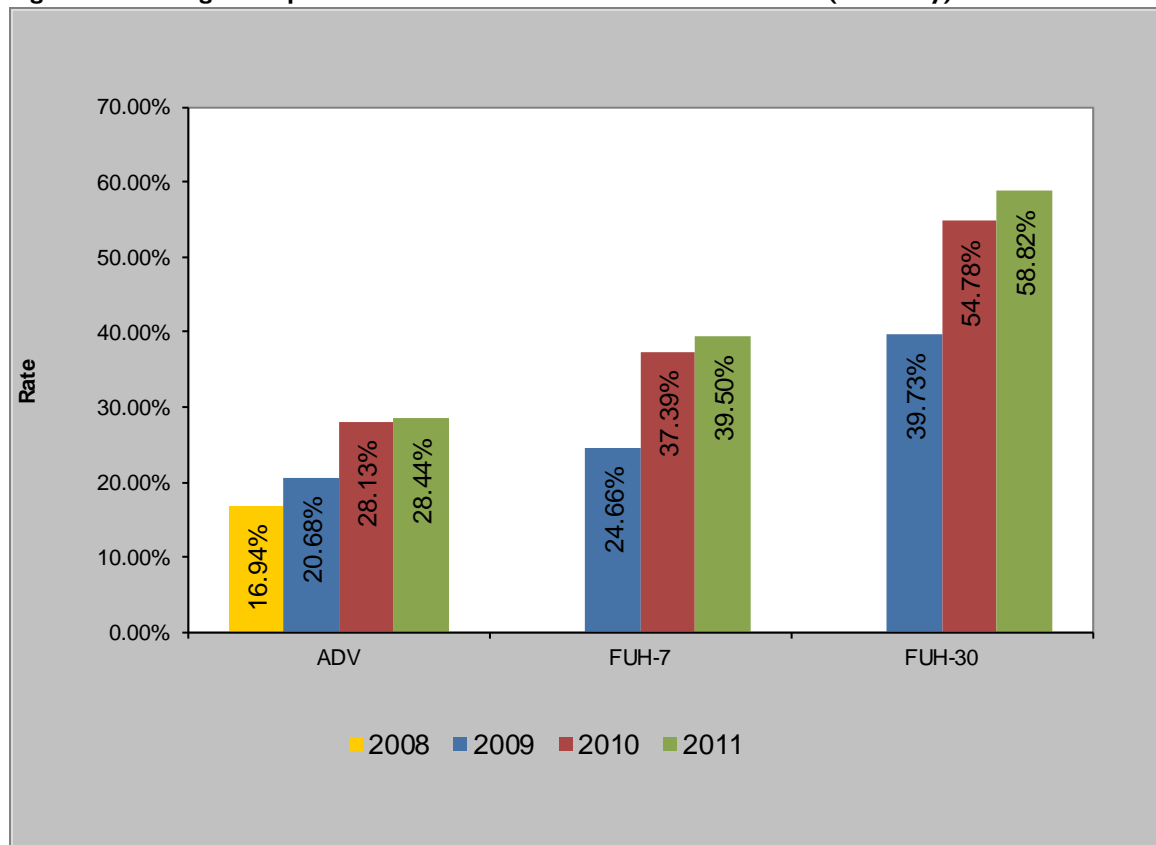
The 7-day reported rate for Harmony for the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure was 39.50% which was **significantly lower** than the statewide rate for all MCHPs (45.60%; $z = -0.47$, 95% CI: 32.93%, 46.06%; $p < .05$). This is slightly **higher** than the rate previously reported in 2010 (28.13%; see Table 31 and Figure 42).

The HEDIS 2011 30-day rate for Follow-Up After Hospitalization for Mental Illness reported by Harmony was 58.82%, **significantly lower** than the statewide rate for MCHPs (66.22%, $z = 1.89$; 95% CI: 52.25%, 65.39%; $p < .05$). This rate is **higher** than the rate of 54.78% previously reported by the MCHP in 2010 (see Table 31 and Figure 42).

Table 31–Reported Performance Measures Rates Across Audit Years (Harmony)

Measure	HEDIS 2008 Rate	HEDIS 2009 Rate	HEDIS 2010 Rate	HEDIS 2011 Rate
Annual Dental Visit (ADV)	16.94%	20.68%	28.13%	28.44%
Childhood Immunizations Status – Combination 3 (CIS3)	NA	NA	NA	47.93%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	NA	24.66%	37.39%	39.50%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	NA	39.73%	54.78%	58.82%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year

Figure 42 – Change in Reported Performance Measure Rates Over Time (Harmony)

Sources: BHC, Inc. 2008-2011 External Quality Review Performance Measure Validation Reports

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The

findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the CMS Protocol Attachments.

DATA INTEGRATION AND CONTROL

Information systems management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing and reporting. The EQRO was provided with a demonstration of the HEDIS repository.

For all three measures, Harmony was found to meet all of the criteria for having procedures in place to produce complete and accurate data . There were no biases or errors found in the manner in which Harmony transferred data into the repository used for calculating the HEDIS 2011 measures.

DOCUMENTATION OF DATA AND PROCESSES

Data and processes used for the calculation of measures were adequate . Harmony met all criteria that applied for all three measures.

PROCESSES USED TO PRODUCE DENOMINATORS

Harmony met all criteria for the processes employed to produce the denominators of all three performance measures . This involved the selection of members eligible for the services being measured. The EQRO found the age ranges, dates of enrollment, medical events, and continuous enrollment criteria were programmed to include only those members who met HEDIS 2011 criteria.

For the Follow-Up After Hospitalization for Mental Illness measure, 119 eligible members were reported and validated by the EQRO.

For the denominator of the Adolescent Well-Care Visits measure a sample of 612 eligible members were reported and validated.

The Annual Dental Visit denominator included 7,569 reported and EQRO-validated eligible members.

PROCESSES USED TO PRODUCE NUMERATORS

All three measures included the appropriate data ranges for the qualifying events (e.g., well-care visits, follow-up visits, and dental visits) as specified by the HEDIS 2011 criteria. A medical record review was conducted for the Childhood Immunizations Status measure.

For the HEDIS 2011 Annual Dental Visit measure, the EQRO validated 2,150 hits from administrative data, while 2,153 were reported. The MCHP's reported rate was 28.44% and the EQRO validated rate was 28.41%, resulting in a bias (overestimate by the MCHP) of 0.03%.

For the Childhood Immunizations Status measure, Harmony reported 150 administrative hits; the EQRO's validation of the data yielded 148 hits. For the medical record review validation, the EQRO requested 30 records. A total of 30 records were received for review, and all 30 of those were validated as hits by the EQRO. Therefore, the percentage of medical records validated by the EQRO was 100.00%. The rate calculated by the EQRO based on validated administrative and hybrid hits was 47.45%, while the plan reported a total rate of 47.93%. This represents a bias of 0.48%, an over-estimate by the MCHP.

For the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure (7-day rate), the MCHP reported 47 hits, and 45 were verified by the EQRO. This yielded a reported rate of 39.50% and a validated rate of 37.82%; an overestimated bias by the MCHP of 1.68%.

The number of hits reported by Harmony for the Follow-Up After Hospitalization for Mental Illness measure 30-day follow-up was 70; the EQRO found 69 valid hits. The rate reported by

the MCHP was 58.82% and the rate validated by the EQRO was 57.98%, a bias (overestimate) of 0.84%.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Adolescent Well-Care Visits measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure.

SUBMISSION OF MEASURES TO THE STATE

Harmony submitted the Data Submission Tool (DST) for each of the three measures validated to the SPHA (the Missouri Department of Health and Senior Services; DHSS) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS

The following table shows the estimated bias and the direction of bias found by the EQRO. All three measures were overestimated, but these results still fell within the 95% confidence interval reported by the MCHP.

Table 32 - Estimate of Bias in Reporting of Harmony HEDIS 2011 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	0.03%	Overestimate
Childhood Immunizations Status (Combination 3)	0.48%	Overestimate
Follow-Up After Hospitalization for Mental Illness (7-day)	1.68%	Overestimate
Follow-Up After Hospitalization for Mental Illness (30-day)	0.84%	Overestimate

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources summarized in the Final Performance Measure Validation Worksheet for each measure.

Table 33 - Final Audit Rating for Harmony Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Substantially Compliant
Adolescent Well-Care Visits	Substantially Compliant
Follow-Up After Hospitalization for Mental Illness	Substantially Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCHP. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No Managed Care Members qualified for the measure.

CONCLUSIONS

Three performance measure rates were reported and validated for Harmony. All three of these rates (Follow-Up After Hospitalization, Annual Dental Visit, and Childhood Immunizations Status) were all **significantly lower** than the average for all MCHPs.

QUALITY OF CARE

Harmony's calculation of the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure was substantially compliant with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered.

The 7-day rate for this measure was **significantly lower** than the statewide average for all MCHPs. The 30-day rate reported by the MCHP for this measure was also **significantly lower** than the average for all MCHPs. Both rates were below both the National Medicaid and National Commercial Averages. This indicates that Harmony members are receiving **lower** quality of care, for both the 7-day and 30-day timeframes, than the average National Medicaid

and National Commercial members. Within both the 7-day and 30-day timeframes, Harmony members are receiving a **lower** quality of care than the quality received by the average Managed Care member.

ACCESS TO CARE

Harmony's calculation for the HEDIS 2011 Annual Dental Visit measure was substantially compliant with specifications; this measure is categorized as an Access/Availability of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving.

The MCHP's reported rate for this measure was **significantly lower** than the average for all MCHPs. Harmony members are receiving a quality of care that is **lower** than the level of care delivered to the average Managed Care member. This rate is also **lower** than the National Medicaid Average, indicating the MCHP's members receive a **lower** access to care than the average Medicaid member nationwide.

TIMELINESS OF CARE

Harmony's calculation of the HEDIS 2011 Childhood Immunizations Status measure was substantially compliant. This measure is categorized as Effectiveness of Care measure and aims to measure the timeliness of the care received.

The MCHP's reported rate for this measure was **significantly lower** than the overall MCHPs calculated rate. Harmony's members are receiving the timeliness of care for this measure at a **lower** level than the care delivered to all other Managed Care members. This rate was **lower** than both the National Commercial Rate and the National Medicaid Rate, indicating that Harmony's members are receiving the care in a **less** timely manner for this measure than the average Commercial or Medicaid member across the nation.

RECOMMENDATIONS

1. All four of the rates validated for this MCHP were **significantly lower** than the all-MCHP averages. The EQRO recommends that the MCHP study these rates to reverse this trend.
2. Work to **increase** rates for all measures, as all 4 were below the National Medicaid averages.
3. All four rates showed a bias of overestimation. The EQRO recommends that the MCHP review their data collection, integration, and measure calculation practices to help alleviate this issue.
4. Continue to conduct and document statistical comparisons on rates from year to year.
5. Continue to utilize the Hybrid methodology for calculating rates when allowed by the specifications.

8.3 MCHP Compliance with Managed Care Regulations

METHODS

Harmony Health Plan of Missouri (Harmony) was subject to a follow up compliance audit during this on-site review. The content of this 2011 calendar year audit will include all components of the Quality Standards as defined in 42 CFR 438. Evaluation of these components included review of:

- Defined organizational structure with corresponding committee minutes
- Policies and Procedures
- Organizational protocols
- Print materials available to members and providers
- Report results
- Staff interviews

The Team utilized an administrative review tool which was developed based on the CMS Protocol Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient MCHPs (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Regulations (Compliance Protocol). The evaluation included review of MCCI's compliance with Access Standards, Structure and Operations Standards, and Measurement and Improvement Standards. Utilizing these tools, Harmony will be evaluated on the timeliness, access, and quality of care provided. This report will then incorporate a discussion of the MCHP's strengths and weaknesses with recommendations for improvement to enhance overall performance and compliance with standards.

The EQRO rating scale remains as it was during the last evaluation period.

M = Met

Documentation supports that all components were implemented, reviewed, revised, and/or further developed.

PM = Partially Met

Documentation supports some but not all components were present.

N = Not Met

No documentation found to substantiate this component.

N/A = Not Applicable.

Component is not applicable to the focus of the evaluation. N/A scores will be adjusted for the scoring denominators and numerators.

A summary for compliance for all evaluated Quality Standards is included in Table 34.

Table 34 - Comparison of Harmony Compliance Ratings for Compliance Review Years (2009, 2010, 2011)

Measure	2009	2010	2011
<i>Enrollee Rights and Protections</i>	69.2%	100%	100%
<i>Access and Availability</i>	47.05%	70.6%	70.6%
<i>Structure and Operations</i>	60%	100%	100%
<i>Measurement and Improvement</i>	63.63%	72.7%	90.9%
<i>Grievance Systems</i>	0%	33.3%	77.7%

Description of the Data:

The review of Quality Standards was completed using a Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations.

FINDINGS

Enrollee Rights and Protections

Enrollee Rights and Protections address 13 standards. For the 2011 review, Harmony was rated by the review team to have met all 13 standards. This is an overall rating of 100% compliance, which is significantly **higher** than the 2009 rate (69.2%) and consistent with the rating received in 2010.

The rating for Enrollee Rights and Protections (100.0%) reflects the second consecutive year that Harmony has complete and approved policy and procedures. This is the MCHP's fifth compliance review. Harmony was able to have all policy and procedures submitted and approved by the SMA in a timely manner. The MCHP provided evidence of their practice throughout the on-site review process. It appears that the MCHP is in compliance with all Managed Care contract regulations and federal requirements.

Harmony Health Plan of Missouri is a part of WellCare MCHPs, Inc., whose home offices are located in Tampa, Florida. Harmony has been providing Medicaid Managed Care Services in states other than Missouri for a number of years.

Harmony has a Medical Advisory Committee. This committee provides oversight of Customer Service Initiatives, such as the development and use of the Customer Satisfaction Survey. The Medical Advisory Committee reports its findings to the Physicians' Committee, which has led them to believe there continues to be a need for outreach and provider education.

The MCHP continues to operate a Consumer Advisory Work Group. This Group reviews the information provided by the Customer Satisfaction Survey. They assist in developing training topics. In the past year training has included Compliance Training which has focused on correctly interpreting policy and procedures specific to the Missouri project.

Access Standards

Access and Availability addresses 17 standards. For the 2011 review, Harmony was rated by the review team to have met 12 standards. This is an overall rating of 70.6% compliance, which is consistent with the ratings received in 2010 and an improvement over the 47.05% rating received in 2009.

Harmony submitted required policy and procedures to the SMA for their approval. However, in reviewing records and interviewing staff full evidence of assessments and treatment planning for members was not available. These findings are detailed more specifically in the Special Project, Section 4 of this report.

Harmony continues to make an effort to improve in the area of access standards. The MCHP has submitting policies and procedures pertaining to this area of review to the SMA as required. The MCHP is actively working to increase their provider panel throughout the Managed Care Eastern Region, including active recruitment in the counties outside of St. Louis City and St. Louis County.

The Administrative staff reports that they continue to focus on recruiting providers and urgent care centers with after-hours access. Physicians were contacted regarding their contractual

requirements to provide after-hour access to services. A number of physician groups hired additional doctors. However, the MCHP still continues to operate without a hospital in their network that is in close proximity to many of their out-lying Eastern Region counties.

Ratings for compliance with Access Standards (70.6%), were consistent with the 2010 rating. The MCHP has complete and approved policy in many of the areas that it had lacked during prior year's reviews. However, in reviewing case management records and interviewing staff, full evidence of assessments and treatment planning for members was not available.

Structures and Operation Standards

The area of Structures and Operations addresses 10 standards. For the 2011 review, Harmony was rated by the review team to have met all 10 standards. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2010 and a significant improvement over the 2009 rating (60%). The ratings for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the second year. The MCHP appears to be compliant with all policy and practice in this area that meets SMA contract compliance and federal regulations.

Harmony continues to develop their credentialing standards. The MCHP received NCQA Accreditation during the 2011 calendar year and that process greatly enhanced Harmony's credentialing standards, as well as other Operational areas.

The MCHP operates a dedicated quality improvement program that includes an active Medical Advisory Committee. They also operate physician outreach and education programs to enhance their ability to communicate and support providers. This includes one-on-one physician education sessions. They utilize provider newsletters and other outreach activities to provide information and feedback to the provider network.

Measurement and Improvement

Measurement and Improvement addresses 12 standards. For the 2011 review, Harmony was rated by the review team to have met 10 standards; one standard was found to be Not Applicable. This is an overall rating of 90.9% compliance, which is a significant improvement

over the ratings received in 2009 (63.63%) and 2010 (72.7%). This rating reflects that all required policy and practice meets the requirements of the Managed Care contract and the federal regulations.

Harmony is continuing to improve their Quality Assessment and Performance Improvement activities during 2011. Their Quality Improvement group meets regularly and includes local physicians who actively participate. The MCHP's goal of providing quality services to members was a significant focus of the MCHP's discussions. The MCHP reports that the Quality Improvement section is an active and essential part of operations.

Harmony did submit two Performance Improvement Projects (PIPs) for validation. These PIPs were much improved over prior year submissions, but lacked clarity and were difficult to decipher. The structure of both PIPs did follow the federal protocol.

The MCHP was required to submit information for Validation of Performance Measures for validation. All three Measures were available for validation. Harmony continued to operate a health information system within the guidelines of that protocol. The complete details of each of these areas of validation can be reviewed within specific sections of this report.

Grievance Systems

Grievance Systems addresses 18 standards. For the 2011 review, Harmony was rated by the review team to have met 14 standards; four standards were rated as Partially Met. This is an overall rating of 77.7% compliance, which is **significantly higher** than the ratings received in 2010 (33.3%) and 2009 (0.0%).

Ratings for compliance with the Grievance Systems regulations (77.7%) indicate that the MCHP completed most of the requirements regarding policy and practice.

Ratings for compliance with the Grievance Systems regulations (94.4%) indicate that the MCHP completed most of the requirements regarding policy and practice. This is the first in six years that the MCHP is not fully compliant in this section of the review.

The EQRO reviewed grievance and appeals files while on-site at Harmony, in St. Louis, MO, on Tuesday, June 26, 2012. The EQRO Project Director, Amy McCurry Schwartz, read 39 files and completed an analysis tool for each file reviewed. These files were reviewed for compliance with Federal Regulations and the MCHP's State Contract. The table below summarizes the findings of this file review.

Table 35 – Compliance File Review, Harmony

MCHP	# of records reviewed	# with issue	% with issues	% Correct
Harmony	39	6	15.38%	84.62%

The specific issues identified by the Project Director in Harmony's files included the following:

- Written notice of disposition of Grievance letter included severe typographical errors or grammar that was undecipherable (5 files)
- Dates contained in letter were inaccurate (1 file)

Harmony showed **significant improvement** in this area of the review, in 2010 the MCHP received a rating of 34.48% correct in the Grievance and Appeals File review in contrast to the 2011 rating of 84.62% correct.

Although not specifically attributable to this MCHP, it is noted that the mandatory language required by the State of Missouri in all Notice of Action letters is considered confusing by the EQRO. The language contained in the clause related to the member's right to "Continuation of Services" and the requirement to list all legal aid offices in the State of Missouri and not the one specific to the member's address both serve to make the letter confusing.

The rating for the Grievance System 77.7% is an improvement over prior years' ratings, and it does seem that the practices observed at the time of the on-site review indicated that Harmony has gained an understanding regarding operation of a grievance and appeals system.

State Inquiry Log review

The EQRO also reviewed the MCHP's response to any "inquiries" received by the SMA during the fourth quarter of Calendar year 2011 that pertained to a Harmony member. Harmony did not have a specific procedure in place for dealing with "State Inquiries", these inquiries were

logged by the Customer Service staff in the MCHP's call logging system. If Customer Service is able to resolve the issue over the phone it is handled there, if the issue requires additional time/attention it is forwarded to the Grievance and Appeals staff. For this review, seven inquiries were received by the SMA during 4QCY11 for Harmony members. According to the MCHP, none of these issues were handled by the Grievance and Appeals group.

However, unlike many other MCHP's, Harmony did not supply the EQR team with the Customer Service notes for any of the inquiries.

CONCLUSIONS

Harmony staff is able to articulate their MCHP's goals and the requirements for service delivery associated with the Managed Care contract and the federal guidelines. The MCHP is familiar with the requirements in meeting all written policies and procedures and has improved in receiving SMA approval of the Missouri specific policy that has been submitted.

Unfortunately, the MCHP has not been able to exhibit that they are able to meet all member service needs, particularly in the area of case management and working with members with special health care needs. They have reportedly implemented a number of improvement strategies, including upgrades to their case management system. However, these improvements were not yet reflected in the cases reviewed for 2010 or 2011. A bright spot was seen in OB case management, but unfortunately, this was the only area where Case Management seemed to be working.

QUALITY OF CARE

The Harmony staff state an awareness of their responsibility to ensure adequate access to quality healthcare in a timely manner. They voiced their awareness that creating an environment where all member services meet their quality standards must continue.

However, it was not evident in practice that Harmony was providing the quality of services of which they spoke. Case Management was fraught with issues. There was little to no evidence

of Assessments or Treatment Plans in the Case Management review. In most of the Case Management files there were few if any attempts to contact members and offer services.

Grievance and Appeals files were greatly improved from the 2010 review, this is evidence that the MCHP attempted to implement many of the Quality of Care recommendations made by the EQRO during the 2010 review.

ACCESS TO CARE

Harmony has improved their provider network and continues to fully develop all service delivery in their Managed Care region. The MCHP does however, still lack a hospital that provides services to many of the out-lying counties in the Eastern Region.

The case management staff express an understanding of the importance of access to care for members and provide examples of their efforts in meeting this requirement. The information obtained during the on-site review reflects improved collaboration between departments within the MCHP. However, little evidence of Case Management and Care Coordination was present in the case files reviewed by the EQRO. In fact, the EQR reviewers were very concerned about some of the cases that they reviewed.

TIMELINESS OF CARE

Harmony staff stated an awareness of the importance of timeliness in the provision of health care to members. This is an area where complete and approved policy is the foundation for ensuring that members receive services in a timely fashion, have a timely response to a question, and a timely turnaround on issues such as grievances and appeals. Fortunately, the EQRO found significant improvements in the areas of grievances and appeals. The timeliness issues identified in the 2010 EQR report were not evident in this year's review. It seemed that Harmony had made a valiant attempt to improve in this area.

RECOMMENDATIONS

1. Ensure that staff (located outside of the State of Missouri) who serve MO HealthNet Managed Care members are adequately trained in the specifics of responding to the member's concerns.
2. Continue to utilize direct face-to-face case management in OB cases, this method was a great improvement over prior year reviews.
3. Continue development of efforts to improve community relations.
4. Provide oversight for behavioral health services to ensure that members maintain provider relationships, and continue to receive the services required.
5. Continue the attention to detail in the areas of Grievances and Appeals, the improvements in this area over the 2010 audit were great.

9.0 Healthcare USA

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9.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

HealthCare USA supplied the following documentation for review:

- Decreasing Non-Emergency/Avoidable Emergency Department Utilization
- Statewide Performance Improvement Project – Improving Oral Health

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on June 28, 2012, during the on-site review, and included the following:

Rudy Brennan – Quality Improvement Coordinator
Carol Stephens-Jay – Senior Health Care Consultant
Laurel Ruzas – Director, Quality Improvement (via telephone)
Dale Pfaff – Quality Improvement Coordinator
Larry Reagan – Health Care Consultant

The interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- Discuss the interventions and the outcomes.
- What were the findings?
- What does HCUSA want to study or learn from their PIPs?

The PIPs submitted for validation included a substantive amount of information. Additional analysis has occurred between the time of the original submission of information and the time of the on-site review. HealthCare USA (HCUSA) was instructed that they could submit additional information that included enhanced outcomes at the time of the on-site review. The final evaluation was based on the updated information received.

FINDINGS

CLINICAL PIP – IMPROVING CHILDHOOD IMMUNIZATION RATES

Study Topic

The first PIP evaluated was the clinical PIP submission entitled “Decreasing Non-Emergent/Avoidable Emergency Department Utilization.” The study topic presentation explained the research completed by HCUSA justifying the decision for topic selection. The narrative included national, state and MCHP specific data that provided support for the topic choice. The research looked at member need and the severity of their concerns. This information was supported by a national, regional and local literature review. The topic was based on an evaluation of claims data after HCUSA identified a local trend indicating an increase in the number of Emergency Department (ED) visits in the past few years. The justification for the topic choice informs the goal of improving access and quality of care through ensuring that members obtain the most appropriate health care in the correct setting. The result of focusing plan resources on reducing inappropriate ED utilization is designed to help members access the most appropriate level of care at the right time, and assists in helping them establish a medical home. The goal further identifies research validating that establishing a medical home results in better health on both the individual and population level, and reduces healthcare disparities.

Study Question

The original study question for this project was:

“Will member education regarding ED utilization decrease inappropriate and avoidable ED utilization as evidenced by a 2% reduction in HEDIS utilization rate?”

The study questions have been updated for each study year. The study question for 2011 was:

“Will member education regarding ED utilization decrease inappropriate and avoidable ED utilization as evidenced, by a 2% reduction in the number of ED Frequent Flyer visits?”

The study question is clear and measureable. Each year the updated study question considers the population they wish to serve or impact, and the goal for effecting change.

Study Indicators

The study indicators and their goals were provided. Each indicator provided numerators, denominators, and explained how current data would be compared to the 2006 baseline year. ED Frequent Flyers were defined as “HealthCare USA members that have had three or more ED visits in six months that fall within the Frequent Flyer diagnoses groupings.” Data was provided by region and statewide. What was being measured and the information each indicator will provide was explained. The baseline indicator and the specifications of its development were included in the information provided. The information included adequate documentation to determine if the indicators would measure a change in health status. This also served to explain how they were associated with improved member outcomes. The third indicator and its goals were explained in detail.

Study Population

The performance improvement project is focused on HCUSA members who utilize the ED with diagnoses that are in Frequent Flyer diagnoses categories. These categories are defined by specific CPT codes that are presented in the documentation. Any MCHP member meeting these definitions is included in the study. This information and the rationale for this target group are stated clearly and are supported by the progressive nature of this study. The methodology designed to capture all members to whom the study applies was included and explained.

Study Design and Data Collection Procedures

A study design explained the data collection methodology. How claims are received, loaded into HCUSA’s claims system, and the controls that exist to ensure valid and reliable data were included. The process ensures accuracy. The main source of original data will come from the HEDIS certified software provided by Catalyst. This will be used to identify and count the target population, and to query the MCHP’s claims system. The claims data alone will be used to create the data used to measure the PIP outcomes. How the final data is collected and reviewed is included in the narrative.

The claims data will be run quarterly, and run charts will be used to monitor the impact of the planned interventions. A standardized query is used that extracts data from the Coventry data

warehouse, and allows this to be uploaded into a local Access database. This data will be used to assess ongoing effectiveness of the project. The Frequent Flyer average numbers are determined through a process that was described in detail. Data is collected quarterly and run charts are used to monitor the impact of the interventions and to assess effectiveness. All the processes explained in the PIP narrative ensure valid and reliable data collection and reporting. Although claims data is being utilized to measure outcomes, how the systems work together to produce consistent and accurate data was clearly documented. The importance of this process to producing valid PIP outcomes was provided.

The study design presented specifies the sources of data and why they are applicable. A systematic method of collecting valid and reliable data was verified. The instruments and data collection tools that were used are provided. The prospective data analysis plan summarized how data will be gathered, the process for ensuring valid data, and how it will be analyzed. This was provided for all three indicators. HCUSA will evaluate the ongoing effectiveness of the interventions implemented. Information is then sent to the Emergency Department Performance Improvement Team and the outcomes are reported to the Quality Management Committee at least quarterly. These explanations are contained in the study design, and enhance the prospective data analysis plan.

The name of the project leader was provided. All team members and their qualifications or role in completion of the study were specified.

Improvement Strategies

The interventions utilized in this study, their rationale, and the manner in which they were implemented is described. The interventions are listed by date of inception and by the group to be impacted. Member interventions for 2011 include:

- Development and distribution of an ED Brochure targeting members with 3 or more ED visits (4,051 mailers sent);
- Sending a Provider newsletter containing education about the use of EDs and urgent care centers; and
- Disseminating a first aid brochure to provider offices with a high number of ED frequent flyers.

These interventions were described in detail. Barrier analysis occurred after each measurement period. This section of the narrative provided a great deal of information allowing an assessment of what is being done, the desired outcome, the responsible staff for the intervention, and the date of implementation.

Data Analysis and Interpretation of Results

A yearly analysis of the data is included in the narrative. It was clearly based on the prospective data analysis plan. The analysis begins in 2007 and goes through 2011. Each indicator is explored independently. A thoughtful analysis is presented. The analysis reflected on the interventions that were successful, as well as those that did not have the expected impact. The 2011 HEDIS rate for ED utilization decreased in all three regions. The Central Region showed the greatest decrease and met HCUSA's stated goals. How the interventions interact with one another, and the effect they may have had on the HEDIS measure overall was discussed and analyzed.

The ED Visits/1000 members trended downward in all three regions. Variations and regional differences were analyzed. The probable impact of continued and future interventions on reaching and exceeding stated goals was included. The narrative explains that they have not yet had the desired positive impact on the Frequent Flyer population. The planned future interventions, which the MCHP hopes will create more impact on this population, were included. Continued trends and opportunities for improvement are woven into the discussion. The study documentation included tables and graphs regarding the information collected. The results were explained in sufficient detail in the documentation provided. The analysis was thoughtful, included barrier identification, factors influencing outcomes, and an overall evaluation of the success of the project to date. The analysis provided evidence that the interventions have had an interim impact. The next steps and more strenuous interventions in place during 2011 were described in detail.

Assessment of Improvement Process

The report presents information on interventions utilized through 2011. An extensive evaluation was presented including a detailed statistical analysis. The data indicates an overall downward trend in the number of ED visits made by Frequent Flyers. All three regions met the

stated goal by August of 2011. All three regions continued to meet or exceed the goal for the remainder of the year. Interventions that had a positive impact will be continued. These will be enhanced and expanded as required to continue to achieve positive results.

Conclusion

HCUSA intends to continue and expand interventions that have had an impact on targeted populations. They will identify trends and actionable areas to reduce avoidable ED visits. The data indicates that their current approach, which includes expanding interventions with a positive impact, have created an environment of real improvement. The interventions focused on targeting specific populations will continue, and will be reviewed regularly. This approach promises sustained improvement as well. This PIP provides a high level of confidence that the MCHP will continue to see improvement in the area of reducing avoidable ED visits.

NON-CLINICAL PIP – IMPROVING ORAL HEALTH

Study Design

The second PIP evaluated was the HealthCare USA approach to the Statewide PIP “Improving Oral Health.” This study is a non-clinical project clearly focused on improving members’ health care. The decision to choose this study topic was supported by information provided regarding the MO HealthNet Managed Care Statewide PIP combined report documentation. HealthCare USA personalized their rationale in the topic justification to explain how it is pertinent to their members. The study topic discussion was complete and focused on the needs and circumstances relevant to MCHP members. Regional and national information was utilized from a literature review. The information presented included the validated the connection between oral health and general health, and the importance of including good oral health in the prevention of serious physical health issues. HCUSA presented convincing evidence that this is an important area of concern.

Study Question

The original HCUSA specific study question presented is:

- Statewide – “Will providing the proposed interventions to MO HealthNet Managed Care eligible members from the ages of 2 through 20 years old increase the number of children who receive an annual dental visit by 3% between HEDIS 2010 (data from calendar year 2009) and HEDIS 2011 (data from calendar year 2010)?”

The narrative points out that the 3% increase in the Annual Dental Visit total rates will be measured both as an aggregate of all MCHPs, as well as for each MCHP individually, as part of the statewide PIP initiative.

The updated HCUSA specific questions are:

- “Will member and provider reminders and education improve the HEDIS rate of annual dental visits as evidenced by a 3% increase in 2012 HEDIS annual dental visits?”
- Will the addition of targeted provider-assisted, care-centered promotions and dental events improve the regional HEDIS rates for annual dental visits (ADV) by 3%?”

The inclusion of the second question expands HCUSA’s focus to engaging providers in the improvement process – for the benefit of plan members. The study questions are complete and clear. They recognize that HCUSA’s success is part of the state total, as well as a reflection of their own success.

Study Indicators

The indicator is presented and explained in the narrative in a clear and concise manner. It is concentrated on the HEDIS rate which is quantifiable and measureable. It draws a relationship between the interventions, their association with the study question, and the likelihood that a positive impact will occur. The numerator and denominator are provided.

Study Population

The study population will consist of all MCHP eligible members from the ages of 2 through 20 in the measurement year. No one is excluded.

Study Design

The study design presented all of the data to be collected and the methodology used. It specifies all data sources. A database report is generated from the subcontractor, DentaQuest’s, claims system. This data is then loaded automatically into the Coventry Data Warehouse. It is sent through a series of system set-up controls and quality controls to ensure data accuracy. The narrative explains how the HEDIS Annual Dental Visit rate is calculated for the entire population, how this is loaded into NCQA certified software, with oversight by IT specialists. The narrative describes a systematic method for obtaining and assessing the data

received. The HEDIS outcome reports are produced by a Coventry HEDIS team. Additional details, including the CPT codes to be queried, are all provided. Specifications for data analysis are included. How outcomes are reported is provided. All numerators, denominators and rates are analyzed for validity and consistency. The administrative methodology is used to determine the ADV HEDIS rates. This is described in a manner that gives confidence that accurate and consistent data are produced.

HCUSA points out that their baseline data does not follow the HEDIS “allowable gap” criteria. It believes that all members in the MO HealthNet population should be educated on proper dental care. This section states that the progress of each intervention will be tracked and updated on a quarterly basis. Coventry has developed a new analysis tool in 2010 that allows HCUSA to review, analyze, and compare monthly HEDIS rates. For example, enhanced member and provider education and community outreach are part of the improvement strategy. If these areas need added attention through the measurement year this becomes evident and can be implemented in a timely manner. The prospective data analysis plan is understandable, clearly described, and provides confidence that the PIP was developed with these issues in mind. The team members, their responsibilities, and qualifications are described in detail.

Improvement Strategies

The original HCUSA specific interventions implemented included:

- Floating Dentists (dentists who agree to rotate through rural areas);
- Partnering with Community Advocates and Events;
- Collaboration with schools/nurses; and
- After hours/weekend scheduling.

In 2011 the MCHP improved outreach programming and refined efforts toward member education, member incentives with premium gift items tied to dental care, and events that directly allow for dental opportunities for non-compliant members. Specifically:

- Continued birthday and missed appointment reminders;
- Development and publication of articles for member and provider education;
- Targeted mailings of a new dental postcard to non-compliant members;
- Distribution of toothpaste and dental floss at school related events;
- Sponsoring Doc Bear events that directly allow for dental opportunities for non-compliant members; and
- Promotion of a large, urban dental provider to increase access and development of a Dental Home.

How these interventions are implemented, measured, and are distributed by the MCHP was explained. The MCHP used a detailed barrier analysis to assist in determining the interventions that were applicable, and how they will be utilized to overcome these barriers.

Data Analysis and Interpretation of Results

The findings and the analysis of those findings were well presented in the documentation submitted. The MCHP presented information including baseline and repeat measurements. It presented a barrier analysis and a discussion of environmental factors that might have an impact on outcomes. The analysis looked at the results regionally and analyzed statewide outcomes. The information provided discussed the validity of the interventions and their relationship. The analysis did occur according to their data analysis plan.

The data supporting the improvements in the HEDIS rates was understandable. They were presented for each region and statewide. This included the growth over the base year in percentage points and the percent increase over the base year. In all three regions the aggregate numbers indicate an improvement exceeding the 3% goal. The analysis asserts that the numbers reflect an increased access to providers, and the ability to track and trend information on a monthly basis. The analysis presented included the baseline year, and a year to year, as well as an aggregate improvement rate regionally and statewide. The project leader continues to collect and review ADV rates by region and statewide on a monthly basis. Throughout each measurement year the project manager obtains rates from the QSI database, reports them to the QA&I committee on a quarterly basis, and reports to the HCUSA Dental PIP team semi-annually.

Assessment of the Improvement Process

HCUSA will continue the improvement strategies that were successful. In addition it continues to pursue ways to engage more of their membership into complying with obtaining annual dental visits. The MCHP intends to produce enhanced provider education, institute new member reminder postcards, and to engage dental clinics and scheduling appointments specifically for its

members. The data demonstrates an increased rate of Annual Dental Visits. The initial and continued improvement points to the fact that the interventions utilized had a direct impact on member behavior.

HCUSA argues that real improvement is dependent upon continued education and ongoing change in member behavior. They are committed to continue to provide educational efforts for this purpose. They have devised new interventions to enhance the improvement already achieved. They plan to continue to enhance their efforts to maintain and continue their success. The MCHP will continue the analysis process to maintain the correlation between the improvement activities and the ADV HEDIS rates.

Conclusion

HealthCare USA intends to sustain the improvement they have made by continuing current processes and developing new strategies and interventions. Plans for calendar year 2012 are in place in collaboration with their subcontractor. They do outline the criteria they will use to make future assessments of project outcomes. The approach the MCHP is taking indicates that there is a high probability that this performance improvement process has had the positive results planned. HCUSA has continued strategies planned to ensure that the outcomes achieved to date continue.

CONCLUSIONS

QUALITY OF CARE

Both PIPs seek to improve the quality of services to members. The non-clinical PIP seeks to improve the rates of annual dental visits. HCUSA has experienced success with the interventions developed and hopes they will continue to positively impact member behavior. The focus of the clinical PIP was clearly targeted to improve the quality of health care for member by improving where and when care is provided. The MCHP recognizes that members who obtain care from their PCP are more likely to receive preventive care and screenings based on medical best practices by a provider who is familiar with their history and ongoing health care needs. Their goal is to help members access the most appropriate level of care at the right time in the right place.

ACCESS TO CARE

The clinical PIP had a specific focus on access to care. The study sought to ensure that members receive health care from their PCP at the time it is needed. Providing education on how to develop a medical home improves access to care for members. The non-clinical PIP was based on the theory that improving availability and access to dental care will improve the overall health of the members served. The supporting documentation indicates how these PIPs will improve access to services, and the importance of this factor as major focus on improving member care.

TIMELINESS OF CARE

The services and interventions used in the clinical PIP had the specific outcome of improving the timeliness of appropriate services for any member. In this PIP the areas of access, quality, and timeliness of care were of the utmost importance. The outcomes indicate a positive trend. The MCHP believes that continuing their efforts and interventions will have a strong impact on improving timely and appropriate medical care. The MCHP continues this PIP with new and enhanced interventions. Timely access to care was an important focus of the non-clinical project. The non-clinical PIP considered timeliness in looking at the members obtaining dental screenings yearly. The narrative discussed how the interventions employed would improve the members' awareness of the need for annual screenings, and how the improvement processes utilized reduced barriers to obtaining these services. By striving to assist members in developing a Dental Home, HCUSA will enhance members' ability to access services on a timely basis.

RECOMMENDATIONS

- I. HealthCare USA focused their efforts on improving the timeliness, quality, and access to care for members requiring health care services in the process of each of these Performance Improvement Projects. The non-clinical project information clearly supported the goal of improving services and benefits to members in a timely manner. The information provided for the clinical PIP was strongly associated with improving the quality and access to appropriate health care services for members. Narrative

- information, responding to the requirements of the PIP protocols was well developed and should be continued.
2. The format of all PIPs should contain complete narrative information on all aspects of the project to ensure that the project is understandable and complete. The data analysis included in these PIPs was excellent. This method of reporting outcomes should continue.
 3. HCUSA continued to address how their projects are extended to and pertinent to all the MO HealthNet Regions served. Projects involving HEDIS measures assist in this as rates are provided for each Region. However, some analysis of the regional differences would benefit the project evaluation.
 4. HCUSA indicated that the processes described in both PIPs are to be incorporated in the regular agency processes. This is an important aspect of the PIP process and should occur to ensure that improvements continue on a sustained basis.

9.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validating Performance Measures Protocol for HCUSA. HCUSA submitted the requested documents on or before the due date of February 20, 2012. The EQRO reviewed documentation between February 20, 2012 and June 15, 2012. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The HCUSA NCQA RoadMap for the HEDIS 2011 data reporting year
- HealthcareData.com LLC's Compliance Audit Report for HEDIS 2011
- HCUSA's information systems policies and procedures with regard to calculation of HEDIS 2011 rates
- HCUSA meeting minutes on information system (IS) policies
- A sample of Catalyst's production logs and run controls
- National Council on Quality Assurance (NCQA)-certified HEDIS software certification report from Catalyst Technologies
- Data field definitions & claims file requirements of the Coventry Corporate Data Warehouse
- Data files from the Coventry Corporate Data Warehouse containing the eligible population, numerators and denominators for each of the three measures.
- HEDIS 2011 Data Submission Tool
- HEDIS 2011 product work plan

The following are the data files submitted by HCUSA for review by the EQRO:

- HCUSA Central ADVI | All Enroll File | _V2.csv
- HCUSA Central ADVI | File2.csv
- HCUSA Central CISQI | All Enroll File | _V2.csv
- HCUSA Central CISQI | File2.csv
- HCUSA Central CISQI | File3_V2.csv
- HCUSA Central FUHI | All Enroll File | _V2.csv
- HCUSA Central FUHI | File2.csv
- HCUSA Eastern ADVI | All Enroll File | _V2.csv
- HCUSA Eastern ADVI | File2.csv
- HCUSA Eastern CISQI | All Enroll File | _V2.csv
- HCUSA Eastern CISQI | File2.csv
- HCUSA Eastern CISQI | File3_V2.csv
- HCUSA Eastern FUHI | All Enroll File | _V2.csv
- HCUSA Eastern FUHI | File2.csv
- HCUSA Western ADVI | All Enroll File | _V2.csv
- HCUSA Western ADVI | File2.csv
- HCUSA Western CISQI | All Enroll File | _V2.csv
- HCUSA Western CISQI | File2.csv
- HCUSA Western CISQI | File3_V2.csv
- HCUSA Western FUHI | All Enroll File | _V2.csv
- HCUSA Western FUHI | File2.csv

INTERVIEWS

The EQRO conducted on-site interviews at HCUSA in St. Louis on Tuesday, June 26, 2012 with staff responsible for calculating the HEDIS 2011 performance measures. The objective of the visit was to verify the methods and processes behind the calculation of the three HEDIS 2011 performance measures.

FINDINGS

Two of the HEDIS 2011 measures being reviewed (Annual Dental Visit and Follow-Up After Hospitalization for Mental Illness) were calculated using the Administrative method, and the third measure (Childhood Immunizations Status) was calculated using the Hybrid method.

MCHP to MCHP comparisons of the rates of Annual Dental Visit, Childhood Immunizations Status, and Follow-Up After Hospitalization for Mental Illness measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The combined rate for the HEDIS 2011 Annual Dental Visit measure reported by HCUSA to the SMA and the State Public Health Agency (SPHA) was 43.10%. This was comparable to the statewide rate for all MCHPs (41.84%, $z = 0.51$; 95% CI: 37.88%, 48.33%; n.s.). This rate has trended upward over the past five EQR report years, from 32.23% in 2007 43.10% in 2011 (see Table 36 and Figure 43).

The reported Childhood Immunizations Status rate was 54.63%; this is comparable to the statewide rate for all MCHPs (57.47%; $z = -0.44$, 95% CI: 49.68%, 59.58%; n.s.). This is the first year the Childhood Immunizations Status (combination 3) measure has been audited by the EQRO, and therefore no trend data is available for comparison.

The 7-day rate reported for the Follow-Up After Hospitalization for Mental Illness measure by HCUSA was 50.25%, which is comparable to the statewide rate for all MCHPs (45.61%; $z = 0.84$, 95% CI: 43.68%, 56.82%; n.s.). This rate has continued to rise **higher** than the rates reported by the MCHP during the last periods this measure was audited in HEDIS 2006, 2007, 2009, and 2010 (29.04%, 27.35%, 43.80%, and 48.41% respectively; see Table 36 and Figure 43).

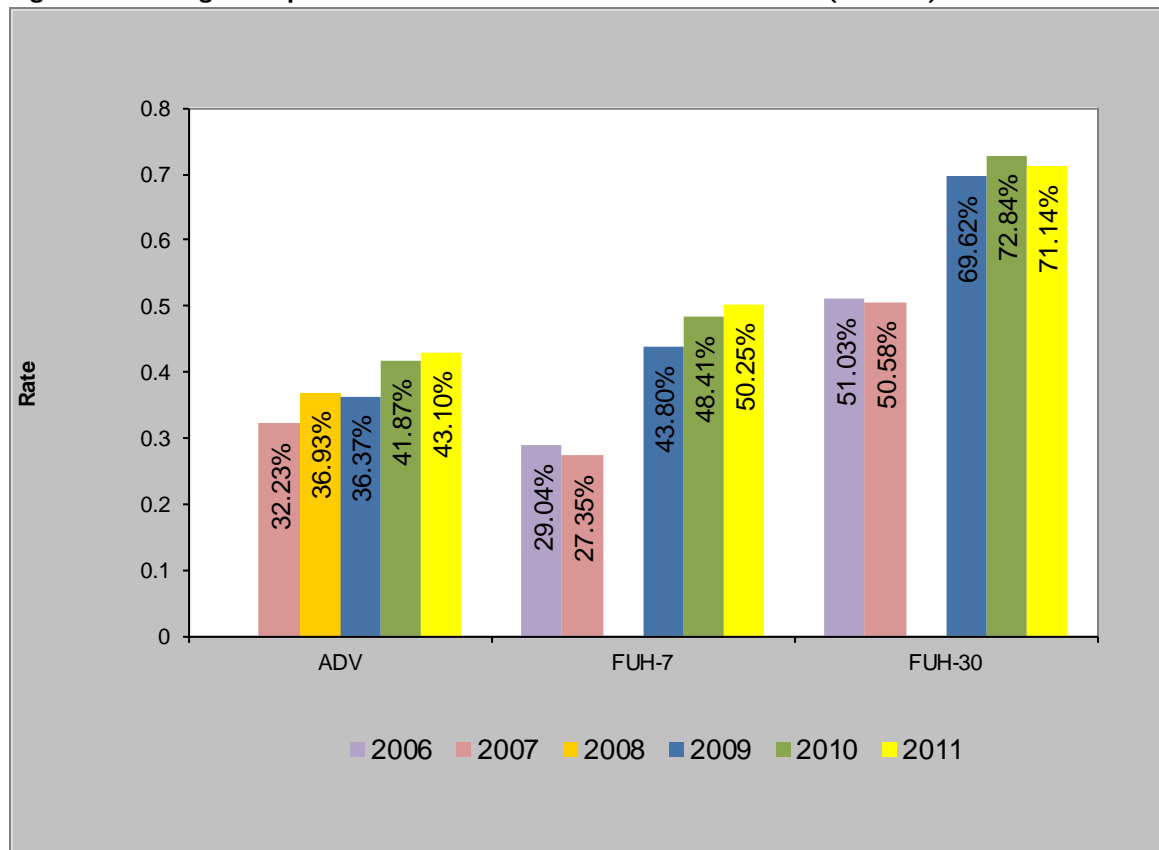
The Follow-Up After Hospitalization for Mental Illness measure 30-day rate reported by the MCHP (71.14%) was also comparable to the statewide rate (66.22%; $z = 3.39$, 95% CI: 64.57%, 77.71%; n.s.). This rate has also continued to trend upward overall, from 51.03% in 2006 to 50.58% in 2007 to 69.62% in 2009 to 72.84% in 2010 (see Table 36 and Figure 43).

Table 36 – Reported Performance Measures Rates Across Audit Years (HCUSA)

Measure	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	HEDIS 2009 Rate	HEDIS 2010 Rate	HEDIS 2011 Rate
Annual Dental Visit (ADV)	NA	32.23%	36.93%	36.37%	41.87%	43.10%
Childhood Immunizations Status – Combination 3 (CIS3)	NA	NA	NA	NA	NA	54.63%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	29.04%	27.35%	NA	43.80%	48.41%	50.25%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	51.03%	50.58%	NA	69.62%	72.84%	71.14%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year

Figure 43 – Change in Reported Performance Measure Rates Over Time (HCUSA)



Sources: BHC, Inc. 2006-2011 External Quality Review Performance Measure Validation Reports

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the main report for activities, ratings, and comments related to the CMS Protocol Attachments.

DATA INTEGRATION AND CONTROL

The information systems management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing and reporting. For all three measures, HCUSA was found to meet all the criteria for producing complete and accurate data. There were no biases or errors found in the manner in which HCUSA transferred data into the repository used for calculating the HEDIS 2011 measures.

DOCUMENTATION OF DATA AND PROCESSES

Although HCUSA uses a proprietary software package to calculate HEDIS measure rates, adequate documentation of this software and its processes was provided to the EQRO for review. The data and processes used for the calculation of measures were acceptable. HCUSA met all criteria that applied for all three measures.

PROCESSES USED TO PRODUCE DENOMINATORS

HCUSA met all criteria for the processes employed to produce the denominators of the performance measures validated. This involves the selection of eligible members for the services being measured. Denominators in the final data files were consistent with those reported on the DST for the three measures validated. All members were unique and the dates of birth ranges were valid.

There were 114,335 eligible members reported and validated for the denominator of the Annual Dental Visit measure.

A total of 8,153 eligible members were reported and validated for the Childhood Immunizations Status measure.

A total of 1,594 eligible members were reported and validated for the denominator of the Follow-Up After Hospitalization for Mental Illness measure.

PROCESSES USED TO PRODUCE NUMERATORS

Two of the three measures were calculated using the Administrative Method (ADV and FUH). The third measure (CIS3) was calculated using the Hybrid method. All measures included the appropriate data ranges for the qualifying events (e.g., well-child visits, follow-up visits, or dental visits) as specified by the HEDIS 2011 Technical Specifications. Appropriate procedures were followed for the sampling of records for medical record reviews.

HCUSA reported a total of 49,283 administrative hits for the Annual Dental Visit measure; 49,201 hits were validated by the EQRO. This resulted in both a reported rate of 43.10% and a validated rate of 43.03%, representing an overestimated bias by the MCHP of 0.07%.

For the HEDIS 2011 Childhood Immunizations Status measure, there were a total of 2,852 administrative hits reported and 2,797 hits found. All 30 of the medical records requested were received, and all 30 were able to be validated by the EQRO. As a result, the medical record review validated 213 of the 213 total hybrid hits reported. Combined with the administrative rates, this yields a reported rate of 54.63% and a validated rate of 53.86%. This indicates a bias (overestimate) of the rate of 0.77% by the MCHP.

The number of administrative hits reported for the 7-day rate for the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure was 801; the EQRO found all 801. This resulted in a reported rate and a validated rate of 50.25%, indicating no bias.

The Follow-Up After Hospitalization for Mental Illness 30-day calculation showed 1,134 reported hits; of these, the EQRO was able to validate all 1,134 of them. This yielded a reported rate and a validated rate of 71.14%, again indicating no bias.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Childhood Immunizations Status measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure. HCUSA was compliant with all specifications for sampling processes.

SUBMISSION OF MEASURES TO THE STATE

HCUSA submitted the Data Submission Tool (DST) for each of the three measures to the SPHA (the Missouri Department of Health and Senior Services) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS

As is shown in Table 37, the MCHP overestimated the Annual Dental Visit and Childhood Immunizations Status measures. No bias was observed in the Follow-Up After Hospitalization for Mental Illness measure.

Table 37 - Estimate of Bias in Reporting of HCUSA HEDIS 2011 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	0.07%	Overestimate
Childhood Immunizations Status (Combination 3)	0.77%	Overestimate
Follow-Up After Hospitalization for Mental Illness (7-day)	No bias	N/A
Follow-Up After Hospitalization for Mental Illness (30-day)	No bias	N/A

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure (see Table 38). The rate for the Annual Dental Visit and Adolescent Well-Care

Visits measures were overestimated, but still fell within the confidence intervals reported by the MCHP. Therefore, these measures were determined to be Substantially Compliant. The Follow-Up After Hospitalization for Mental Illness was Fully Compliant.

Table 38 - Final Audit Rating for HCUSA Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Substantially Compliant
Childhood Immunizations Status	Substantially Compliant
Follow-Up After Hospitalization for Mental Illness	Fully Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCHP. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No Managed Care Members qualified for the measure.

CONCLUSIONS

All three of the MCHP's performance measure reported rates (ADV, CIS, and FUH) were consistent with the average for all MCHPs.

QUALITY OF CARE

HCUSA's calculation of the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure was fully compliant with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered.

HCUSA's rate for this measure was consistent with the average for all MCHPs. The MCHP's members are receiving the quality of care for this measure consistent with the care delivered to all other Managed Care members. Both the 7-day and 30-day rates were above National Medicaid Averages and below the National Commercial Averages for this measure. The MCHP's members are receiving a quality of care for this measure **higher** than the average National Medicaid member but below the average National Commercial member across the country. However, these rates continue to hold steady or rise from the rates reported by the MCHP during the audit of the HEDIS 2006, 2007, 2009, and 2010 measurement years, indicating a continuing improvement in the quality of services received by members overall.



ACCESS TO CARE

The Annual Dental Visit measure was substantially compliant with specifications. This measure is categorized as an Access/Availability of Care measure. Because only one visit is required for a positive “hit”, this measure effectively demonstrates the level of access to care that members are receiving. HCUSA’s reported rate for this measure was comparable to the average for all MCHPs. HCUSA’s members are receiving the quality of care for this measure consistent with the level of care delivered to all other Managed Care members.

This rate was **higher** than the rates reported by the MCHP during the 2007, 2008, 2009, and 2010 reports. This shows that HCUSA members are receiving more dental services than in the past. The MCHP’s dedication to improving this rate is evident in the increasing averages. This rate was below the National Medicaid Average for this measure; the MCHP’s members are receiving a **lower** access to care than the average National Medicaid member.

TIMELINESS OF CARE

The MCHP’s calculation of the HEDIS 2011 Childhood Immunizations Status measure was substantially compliant. This measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received. The MCHP’s reported rate for this measure was consistent with the average for all MCHPs. This rate has not been previously audited by the EQRO and therefore no data is available for a trend analysis.

HCUSA’s members are receiving the timeliness of care for this measure consistent with the care delivered to all other Managed Care members. However, this rate was **lower** than both the National Medicaid and National Commercial averages for this measure. The MCHP’s members are receiving Childhood Immunization care in a manner that is **less** timely than the average Medicaid or Commercial member across the nation.

RECOMMENDATIONS

1. Continue utilize the Hybrid methodology for calculating rates when allowed by the specifications.
2. Continue to conduct and document statistical comparisons on rates from year to year.
3. Work to increase rates for the Annual Dental Visit and Childhood Immunizations Status measures; although they were consistent with the average for all MCHPs, they were well below the National Medicaid averages.
4. HCUSA should thoroughly review both the data request format file and the resultant data extract files for accuracy prior to submitting data to the EQRO. This will ensure that the EQRO receives the most complete data possible for validation, and will allow the EQRO to conduct a full analysis.
5. HCUSA continues to submit CSV files when the EQRO requests @-delimited files. HCUSA must comply with the correct file format when submitting requested information.

9.3 MCHP Compliance with Managed Care Regulations

METHODS

HealthCare USA (HCUSA) was subject to a follow up compliance audit during this on-site review. The content of this 2011 calendar year audit will include all components of the Quality Standards as defined in 42 CFR 438. Evaluation of these components included review of:

- Defined organizational structure with corresponding committee minutes
- Policies and Procedures
- Organizational protocols
- Print materials available to members and providers
- Report results
- Staff interviews

The Team utilized an administrative review tool which was developed based on the CMS Protocol Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient MCHPs (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Regulations (Compliance Protocol). The evaluation included review of MCCI's compliance with Access Standards, Structure and Operations Standards, and Measurement and Improvement Standards. Utilizing these tools, HCUSA will be evaluated on the timeliness, access, and quality of care provided. This report will then incorporate a discussion of the MCHP's strengths and weaknesses with recommendations for improvement to enhance overall performance and compliance with standards.

The EQRO rating scale remains as it was during the last evaluation period.

M = Met

Documentation supports that all components were implemented, reviewed, revised, and/or further developed.

PM = Partially Met

Documentation supports some but not all components were present.

N = Not Met

No documentation found to substantiate this component.

N/A = Not Applicable.

Component is not applicable to the focus of the evaluation. N/A scores will be adjusted for the scoring denominators and numerators.

A summary for compliance for all evaluated Quality Standards is included in Table 39.

Table 39 - Comparison of HCUSA Compliance Ratings for Compliance Review Years (2009, 2010, 2011)

Measure	2009	2010	2011
<i>Enrollee Rights and Protections</i>	100%	100%	100%
<i>Access and Availability</i>	100%	76.5%	76.5%
<i>Structure and Operations</i>	100%	100%	100%
<i>Measurement and Improvement</i>	90.9%	90.9%	90.90%
<i>Grievance Systems</i>	100%	88.9%	94.4%

Description of the Data:

The review of Quality Standards was completed using a Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations.

FINDINGS

Enrollee Rights and Protections

Enrollee Rights and Protections address 13 standards. For the 2011 review, HealthCare USA was rated by the review team to have met all 13 standards. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2009 and 2010.

The rating for Enrollee Rights and Protections (100.0%), reflects HealthCare USA's ability to have all policy and procedures submitted and approved by the SMA in a timely manner for the fifth consecutive year and have practices in place that reflect these policies. The MCHP provided evidence of their practice throughout the on-site review process. It appears that HCUSA is in compliance with all Managed Care contract regulations and federal requirements.

A strong commitment to member rights continues to be a cornerstone of HealthCare USA's service philosophy. The emphasis placed on continuous quality improvement by the MCHP was apparent in both the documentation reviewed and throughout staff interviews. Quality services to members, with a particular emphasis on families and children, were observed within the

organization. HealthCare USA views cultural diversity as an essential component of their interactions with members. The MCHP maintains cultural diversity as a cornerstone of initial and ongoing staff training. HealthCare USA employs staff that speaks different languages and is able to provide written materials in languages other than English. Maintaining the ability to serve a culturally diverse population with a variety of special service needs is shown by the MCHP's approach to their work and to their interactions with members.

The MCHP, in collaboration with MHNet, its BHO, reports making a concerted effort to offer adequate case management services between the two agencies. HealthCare USA reports that having a MHNet liaison on-site has improved coordination of care issues.

Access Standards

Access and Availability addresses 17 standards. For the 2011 review, HCUSA was rated by the review team to have met 13 standards. This is an overall rating of 76.5% compliance, which is consistent with the ratings received in 2010 and a decrease from the 100% rating achieved in 2009.

HealthCare USA continues to work with both members and providers to ensure proper access to services is available. The MCHP maintains a large provider network throughout all three Managed Care regions. They continue to recruit providers to expand available services, particularly in the Central Missouri area. This network enables members to have an adequate choice of both PCPs and specialty providers. The MCHP does authorize the use of out-of-network providers when this will best meet a member's healthcare needs.

The rating regarding Compliance with Access Standards regulations is (76.5%). HealthCare USA submitted required policy and procedures to the SMA for their approval.

- In reviewing records and interviewing staff full evidence of assessments and treatment planning for members was not available.

These findings are detailed more specifically in the Special Project, Section 4 of this report.

During the on-site review the commitment to good case management practice was observed by the staff involved.

Structures and Operation Standards

The area of Structures and Operations addresses 10 standards. For the 2011 review, HCUSA was rated by the review team to have met all 10 standards. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2009 and 2010. The ratings for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the sixth year. The MCHP appears to be compliant with all policy and practice in this area that meets SMA contract compliance and federal regulations.

During the 2011 Calendar Year, the MCHP became NCQA Accredited and continues to follow NCQA standards regarding credentialing. On site visits, to complete credentialing, occur at least annually for PCPs and OB/GYNs. An on-site visit occurs with any office where a complaint has been reported. The MCHP reviews areas related to member safety and cleanliness, which reflect the majority of issues. Some delegated credentialing occurs with larger providers.

HealthCare USA's provider advisory group is operational in all three Managed Care regions. The committee is made up of high volume providers and representatives from across specialties. The sharing of ideas and information pertaining to any member dissatisfaction is encouraged. These groups seek provider feedback and provide information in a framework that allows the MCHP to develop a true partnership with their provider network.

Measurement and Improvement

Measurement and Improvement addresses 12 standards. For the 2011 review, HCUSA was rated by the review team to have met 10 standards; one standard was "Partially Met"; and one standard was found to be Not Applicable. This is an overall rating of 90.9% compliance, which is consistent with the 90.9% ratings received in 2009 and 2010.

HCUSA submitted information to complete the Validation of Performance Measures. They continue to operate a health information system within the guidelines of that protocol. However, HCUS continues to provide requested information in CSV files, not TXT files as requested by the EQRO. All three Performance Measures were validated and in Compliance

with all State and Federal requirements. The details regarding these areas of validation can be reviewed within specific sections of this report.

HCUSA also submitted two Performance Improvement Projects (PIPs) for validation. It was noted that the MCHP utilized projects that had been started, and perfected these projects in an effort to improve services to members during the measurement year. These PIPs were well-constructed and provided adequate information for validation.

Grievance Systems

Grievance Systems addresses 18 standards. For the 2011 review, HCUSA was rated by the review team to have met 17 standards; one standard was rated as Partially Met. This is an overall rating of 94.4% compliance, which is **higher** than the rating received in 2010 (83.3%), but **lower** than the 100% rating received in 2009.

Review of Grievance and Appeals Files

The EQRO reviewed grievance and appeals files while on-site at HealthCare USA on Wednesday, June 26, 2012. The EQRO Project Director, Amy McCurry Schwartz, read 30 files and completed an analysis tool for each file reviewed. These files were reviewed for compliance with Federal Regulations and the MCHP's State Contract. The table below summarizes the findings of this file review.

Table 40 – Compliance File Review, HCUSA

MCHP	# of records reviewed	# with issue	% with issues	% Correct
HCUSA	30	1	3.33%	96.67%

The specific issues identified by the Project Director's file review included:

- No acknowledgement of a grievance letter sent (1 file)

HCUSA showed **improvement** in this area of the review, in 2010 the MCHP received a rating of 88.57% correct in the Grievance and Appeals File review in contrast to the 2011 rating of 96.67% correct.

Ratings for compliance with the Grievance Systems regulations indicate that the MCHP completed most of the requirements regarding policy and practice. This is only the second year in seven years of review that the MCHP is not fully compliant in this section of the review.

Although not specifically attributable to this MCHP, it is noted that the mandatory language required by the State of Missouri in all Notice of Action letters is considered confusing by the EQRO. The language contained in the clause related to the member's right to "Continuation of Services" and the requirement to list all legal aid offices in the State of Missouri and not the one specific to the member's address both serve to make the letter confusing.

State Inquiry Log review

The EQRO also reviewed the MCHP's response to any "inquiries" received by the SMA during the fourth quarter of Calendar year 2011 that pertained to a HealthCare USA member. HCUSA has a specific procedure in place for dealing with "State Inquiries". These inquiries are made directly to HCUSA's Director, Government Relations and Regulatory Affairs and investigated by that office. HCUSA made files available to the EQR team of all the State Inquiries that were received. Of the 43 inquiries that the EQR was asked to review, the team felt that three of those should have been handled as a Grievance/Appeal, these were however, resolved quickly and the EQR team was able to review the complete actions of HCUSA in the files.

However, unlike many other MCHP's, HCUSA supplied the EQR with complete files for all the State Inquiries that were reviewed.

CONCLUSIONS

HealthCare USA continues to exhibit a commitment to completing, submitting and gaining approval of required policy and procedures by the SMA, and developing operations that ensure that these procedures are reflected in daily operations. The MCHP maintained improvements to achieve 100% compliance in two sections of the protocol for the fifth year.

The MCHP incorporated methods to track required policy submission into daily administrative practice and took this process seriously. The practice observed at the time of the on-site review provided confidence that services to members is their primary focus and that there was a commitment to comply with the requirements of the Managed Care contract and federal regulations.

However, a few issues were identified during this year's review, including:

- Missing treatment plans and assessments from Case Management files.
- Incorrect format used in data submissions for the Validation of Performance Measure.
- Missing or incorrect information included in responses to Grievances and/or Appeals.

QUALITY OF CARE

The staff at HealthCare USA exhibits a commitment to excellence that creates an atmosphere where both members and providers experience quality services. The provider relations staff made regular contacts with providers to troubleshoot problems that may be reported by members, and to assist provider staff in making interactions with members and the MCHP less complicated. Case Managers relate the importance placed on training and collaboration to ensure that they are aware of issues that may arise and can respond quickly and efficiently to ensure that members have access to quality health care.

However, the EQRO did not receive documentation of all the quality services described by MCHP staff. Treatment planning, assessments and care coordination were areas that the EQRO could not fully validate.

ACCESS TO CARE

HealthCare USA provided numerous examples of initiatives they are involved in to ensure that members have information on obtaining services and have adequate access to services. Several projects were explained that bring providers directly to places where members are available. The MCHP has also undertaken provider recruitment and retention efforts that ensure that providers are available to members throughout all three MO HealthNet Managed Care Regions served.

Internally HealthCare USA, as an organization, has made efforts to ensure interdepartmental integration to create thorough knowledge of their service delivery system thus enabling staff to assist members effectively. Staff exhibited enthusiasm in describing the services they deliver and a desire to ensure that members' health care needs are met in spite of the barriers sometimes experienced.

TIMELINESS OF CARE

HealthCare USA was able to complete all required policies and procedures in a timely manner, to ensure compliance with State contract requirements and federal regulations. The focus on obtaining timely health care services and responses to member needs reflects the attention needed to effectively provide a managed system of services to members.

HealthCare USA improved in the area of Grievances and Appeals from the prior year's review and only one timeliness issues was found in the file review conducted in that area.

RECOMMENDATIONS

1. Make every effort to supply the EQRO with all relevant information for every case file, grievance file, policy or procedure requested. The lack of information that was provided to the reviewers explains many of HCUSA's **lower** rates in this year's review.
2. Provide all requested Performance Measure information in the format requested by the EQRO.
3. Retain the focus on complying with documentation requirements to the same standards as those reflected in the daily practice within the MCHP.

4. Maintain involvement in community-based services and activities.
5. Continue training efforts with front line staff to ensure that they are versed in MCHP policy and procedures and remain confident in their interactions with and advocacy for members. Be sure that staff who are responsible for written communication with members display an attention to detail so that those letters represent the quality of HCUSA's service delivery.

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10.0 Missouri Care MCHP



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10.1 Performance Improvement Projects

METHODS

Document Review

Missouri Care supplied the following documentation for review:

- Increased Use of Controller Medication for Members with Persistent Asthma
- Statewide Performance Improvement Project – Improving Oral Health

Interviews

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team June 19, 2012, during the on-site review, and included the following:

- Christina Schmidl – Quality Management HEDIS Consultant
- Lovey Barnes – Government Relations Consultant
- Erin Dinkel – Quality Management Nurse Consultant
- Mark Kapp – Quality Management and Accreditation Manager

The interviewees shared information on the validation methods, study design, and findings.

Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- Who were the staff involved in this project and what were their roles?
- Discuss the findings and how they were interpreted.
- How were the interventions determined and why did the MCHP choose this approach?
- Are these studies ongoing?
- Discuss the effects of these interventions and how they impacted services to members.

The PIPs submitted for validation did contain significant information allowing initial evaluation.

The MCHP was instructed that during the site visit that they could submit additional information including updates to the outcomes of the interventions or additional data analysis. Additional information was received for these PIPs.

FINDINGS

CLINICAL PIP – DECREASING EMERGENCY DEPARTMENT UTILIZATION

Study Topic

The first PIP evaluated was “Decreasing Emergency Department Utilization.” This PIP is a clinical project. Missouri Care explained the use of hospital emergency departments, as a primary source of medical care, by the Medicaid population. The research points out that in the last decade the number of both inpatient and emergency department beds have decreased. However, they point out that in rural and urban areas there are fewer primary care physicians available, leading to a dependence on emergency medicine. The MCHP explained how these facts are pertinent to their members, and how relying on emergency departments is not in the best interest of the members served. Missouri Care’s rates for use of emergency departments, as opposed to contacting their PCP, are above the 75th percentile, according to NCQA findings. They used several interventions to reduce ED usage, but their rate did not improve. These facts indicated that they need to develop a better approach so the decision was made to implement a Performance Improvement Project targeting this issue.

Missouri Care developed a hypothesis that member and provider education regarding the importance of members utilizing their PCP for non-urgent care will lead to reducing the dependence on emergency services, and an increase in the members following-up with their PCP after an ED visit.

Study Question

The study question presented was:

“Will the targeted interventions to members and providers decrease the total number of ambulatory visits to the ED by 3% and the total number of avoidable and inappropriate ED usage by Missouri Care members by 2% and increase the number of members who follow-up with their PCP after an ED visit?”

This study question is designed to answer the baseline question that MCHP presented. They recognize that they have other questions surrounding this issue, but feel this generalized question is the best way to start this project. The question presented is measureable and specifies the goals for the project. They realize that complexities exist in attempting to address this problem. They are taking this into consideration as the PIP moves forward.

Study Indicators

The study indicators that will be used are:

1. Annual AMB-ER HEDIS rate. Missouri Care wants to measure the number of members who use hospital emergency departments. This will be measured by the AMB-ED measure as calculated as explained in the technical specifications.
2. Rolling 12-Month AMB-ED HEDIS-Like rate. This measure is similar to that explained in #1. However, the measure's statistics are calculated monthly for the MCHP members, the enrollment requirement is waived. They believe this will provide almost a "real time" look at MCHP members using the ED and to assess the interventions in place.
3. Percent of Inappropriate ED Visits compared to the Total ED Visits – This indicator will come from an internal report generated from QNXT, Missouri Care's claims system. It will be a monthly rolling report. It shows members actually seen at the ED, and those coded as inappropriate.
4. Follow-Up with the PCP after an ED visit – This indicator will also be pulled from the QNXT system.

Study Population

The narrative implied that the study is applicable to all Missouri Care members who use any emergency department. The discussion does not include the targeted population. In presenting the HEDIS technical specifications the information states that the AMB-ED measure "...excludes members who visited the ED for mental health and chemical dependency services that did not result in an inpatient stay..." When questioned the MCHP stated that this is part of the HEDIS tech specs and would be incorporated into their results.

Sampling

No sampling will be used in this PIP.

Study Design and Data Collection Procedures

The study design presents all data to be collected and the data sources. Details are provided about the Missouri Care systems, the software used, and the methodology for systems queries. This information is presented for each study indicator. The QNXT system is used to house the

encounter and claims information. This is the primary source of information for data collection. The data elements are determined by the HEDIS technical specifications. Each indicator will provide data consisting of the measurement period, the numerator, the denominator, and the rate. The codes and the timeframes used for each indicator are included.

Missouri Care explains that they can make some assumptions concerning the collection of valid and reliable data. How the HEDIS data is captured and validated through their vendor is included. The processes are explained in a manner that provides confidence in the study design. How data will be collected and utilized to report the success of the project is understandable and thorough. The PIP team obtains the data and updates the PIP. Instruments used and the methodology employed by the team were explained in detail. Current data is reviewed monthly to monitor the effectiveness of the interventions, based on rate trends throughout the year.

A prospective data analysis plan was described, including all planned analysis and a prospective look at the definition of success of the intervention. The confidence level in all data obtained and evaluated was discussed. The prospective data analysis plan discussed obtaining quantitative data, and provided adequate information about how this information would be evaluated.

The MCHP personnel involved in this study, including the project leader, their roles and qualifications were included.

Improvement Strategies

The proposed improvement strategies began in 2010 and included:

- ED Handout and Wallet Card – These are sent to each head of household. A Magnet is also available and will be distributed at Back to School fairs and health fairs.
- Letters to Emergency Departments – Letters were sent to network emergency departments asking that Missouri Care members presenting at the ED with a non-emergent issue, be instructed to contact their PCP for follow up. The MCHP is encouraging a coordination of care between the ED and the PCP, hoping to create increased outpatient visits.
- Provider Relations Intervention – Provider Relations and the Medical Director visited the clinics with the highest ED usage and asked them to reach out to their internal providers, as well as their patients who inappropriately utilize the ED. A letter template was created for those providers/clinics to send to their patients who used the ED for non-emergent reasons.

In 2011 the MCHP added the following intervention:

- Dental ER Initiative – A joint intervention with DentaQuest, Missouri Care's dental subcontractor, to reach out to all members who visited the ED with a dental issue, to encourage them to visit a dentist.

The MCHP has on-going interventions that include:

- Core List for High Utilizers – There is a core list that identifies those members with high ED usage. Case managers reach out to these members.
- ER Card – A double sided card stating when to go to the ER versus when to visit one's PCP was developed. This card was sent to members from 2007 through February of 2010. It is now given out at health fairs, back to school fairs, and to Missouri Care members in Case Management.

Missouri Care has started a PIP that began in 2010 with interventions specifically designed to impact inappropriate use of the Emergency Department. Interventions included activities at the members and provider level, including engaging the ED in recognizing non-emergent visits and providing MCHP members with alternatives. In 2011 Missouri Care did include one new intervention. However, this intervention was actually used in a separate PIP. Although it is pertinent and may impact this project, there were no project specific interventions introduced in 2011. The MCHP did present a barrier analysis.

Data Analysis and Interpretation of Results

A limited amount of data is available, as this is a new PIP. Missouri Care explains that HEDIS 2010 (calendar 2009) is the baseline for the Central Region. They did not operate in the Eastern and Western Regions until calendar year 2010. HEDIS 2011 data created the baseline for these regions. This is an administrative measure and only includes claims data.

Missouri Care determined that the success of the project is demonstrated by quantitative data reflecting:

1. A decrease in the Ambulatory Care – ER (AMB-ER) HEDIS measure;
2. A decrease in the HEDIS-Like rolling 12-month administrative rates during each quarter of the study;
3. A decrease in the percent of inappropriate ER visits compared to the total number of ER visits;
4. An increase in the number of PCP visits following an ER visit.

Because there is limited data available for the first 2 indicators, no trends can be identified at this time. Indicators 3 and 4 use the 2011 data as their baseline, so no comparative data is available. The interventions employed for the PIP, beginning in 2010, will be analyzed to determine if success is achieved. The methods set up to make assessments for all 4 indicators do mirror the prospective data analysis plan. A barrier analysis is presented. This information recognizes the difficulties members encounter, particularly the lack of education related to the use of the PCP as a primary source of medical care. They plan to continue to measure the impact of the strategies employed, and need for future and enhanced strategies are discussed. The MCHP did present detailed tables with the baseline and remeasurement information that is available. These tables are included as attachments. They are not analyzed and discussed. It would be helpful if these tables were included in the body of the narrative, with a narrative interpretation of what the MCHP believes this evidence means.

There is a section of charts included for each region. These charts depict the MCHP's annual AMB-ER rates from HEDIS 2004 through 2012. They indicate that in the Central Region the Missouri Care's HEDIS rate has trended downward, while the NCQA national percentile shows an upward trend. They determined that the MCHP's recognition of this as a significant issue, and the increased focus on the ED rate, has improved their members' understanding of the importance of PCP visits rather than a dependence on the within the Central Region. Both the Eastern and Western Regions have shown a slight increase. Missouri Care asserts that they will be undertaking improved interventions to ensure success throughout all three regions right away.

Assessment of Improvement Process

The MCHP recognizes that they have practices in place, separate from the PIP that may influence the AMB-ER rate. An example is that members in case management are encouraged to visit their PCP rather than the ED regularly. This will allow the PCP to better manage their medical care and treatment. Missouri Care PCPs are increasingly using member reminders and encouraging members to visit them rather than the ED. They do believe that with continued attention and new and innovative interventions, their data will reflect improvement in all areas of the PIP measurement.

Conclusion

This PIP is relatively new and extended trend data is not yet available. However, this PIP is well constructed and appears to have promise to show success in the future. Measureable interventions that are unique to this PIP are important and with this addition it will give confidence that the MCHP has a commitment to impacting this issue.

NON-CLINICAL PIP – IMPROVING ORAL HEALTH

Study Topic

The second PIP evaluated was the Missouri Care individualized approach to the Statewide PIP “Improving Oral Health.” This is a non-clinical project. The decision to choose this study topic was supported by information provided in the MO HealthNet Managed Care Statewide PIP documentation. The study topic description incorporates the documentation presented in the Statewide PIP into a discussion of its relevance to Missouri Care members. The narrative includes thorough problem identification pertinent to the MCHP. They recognized the CMS recommendations for creating improvement in the area of improved access to dental care in their study topic discussion. A literature and research review occurred and the information relevant to the MCHP population is included. This discussion is member focused, and points out the importance that good dental care plays in preventing serious medical risks.

The study topic presentation includes the relevant population who are members ages 2 – 20 and pregnant women. The stated goal of the PIP is to educate members on the importance of dental health to overall health. Missouri Care intends to provide information to enable members to obtain necessary care.

The hypothesis presented was that members aged 2 – 20 and pregnant women will be more likely to schedule a dental visit after being educated about the medical risks involved from no dental prevention and wellness visits.

Study Question

The study question presented is:

“Will providing educational interventions concerning dental hygiene and the importance of annual preventive dental visits to Missouri Care members from the ages of 2 through 20 years

old and pregnant women result in a 3% increase as measured by the Annual Dental Visit (ADV) HEDIS measure as well as a decrease in the number of preventable dental-related trips to the emergency room?”

This is the same study question as previously presented. The MCHP states that and adds: “Although the study question remains the same, the 3% increase will now apply to the HEDIS rates between HEDIS 2011 to HEDIS 2013.” The outline of the intentions of this PIP and its goals are clearly reflected in this study question. It is somewhat complex, but is also comprehensive.

Study Indicators

The primary study indicator (#1) will be improved rates in the ADV HEDIS measure. The MCHP explains that this is actually a reflection on improving members’ understanding of the importance of good oral hygiene, and obtaining regular dental care. They further state that preventing oral disease will avert unnecessary trips to the emergency room.

Indicator #2 is a rolling 12-Month ADV ‘HEDIS-like’ rate: This measure is similar to Indicator #1; with the exception that continuous enrollment is waived so that the data trends may be tracked on a monthly basis.

Study Population

These indicators are used to focus on members ages 2 – 20, which is defined by the HEDIS technical specifications. However, this PIP states that it also includes pregnant women, who do have access to dental care through the MO HealthNet Managed Care program. The outcomes will be measured using the HEDIS data. The population will be captured using this methodology. How pregnant women will be included is not addressed.

Sampling

There are no sampling techniques used in this study

Study Design and Data Collection

The data collection and analysis approach are well planned to capture all required information to evaluate this study. The narrative clearly described how data would be collected and analyzed.

The CPT codes and systems requirements are all defined. Claims information is received from their subcontractor, DentaQuest. The information provided included sufficient detail, but lacks the complete sense of a true study design. This section is coded as “Met” because the required information is included. The study described the process the MCHP will utilize to extract data monthly and report quarterly.

The specific elements of the HEDIS technical specifications that relate to Annual Dental Visit measure were included. The database reports described will be generated from DentaQuest’s claims processing system. This claims system and the Missouri Care system are to be queried. The information provided gives confidence that consistent and accurate data will occur throughout the study. Claims data for the study will be queried from the QNXT system, which is the MCHP’s claims processing system. The HEDIS-like 12 month rolling calculations are administrative rates. The narrative included enough specificity to ensure confidence that this process was thorough and complete.

A comprehensive prospective data analysis plan was presented. It addressed information about specific activities to occur. The success of this project is to be demonstrated through quantitative reflection about: 1) An increase in the HEDIS-like rolling 12-month administrative rates during each quarter of the study (starting in the 1st quarter of 2010); and 2) the Annual HEDIS Rate for ADV. The prospective data analysis plan provides details and insight into what outcomes the MCHP is seeking, and how it will analyze data to evaluate the success of the project. The instruments for data collection, how they ensure consistent and accurate data are mentioned in the prospective data analysis plan.

The reviewers, their qualifications, and the interrater reliability requirements were included.

Improvement Strategies

The intervention implemented in 2011 is:

1) ER Dental Outreach – DentaQuest, on the MCHP’s behalf, will reach out to all members who went to the ER with a dental diagnosis and encourage them to visit the dentist.

Missouri Care includes actions, which they call “continuous” interventions, that have been in place since 2009 and have continued throughout the study. These include:

1. EPSDT Reminder Postcards – Monthly well-child visit reminder postcards are sent to parents of members 2-20 during the members birthday month. The postcards include reminders about Dental Visits;
2. On-Hold Messages – Information on dental hygiene and the importance of an annual dental visit are placed on the on-hold messaging system at Missouri Care; and
3. Member Newsletters – Articles on the importance of dental hygiene and an annual dental visit are placed in Missouri Care's member newsletter at least one a year.

The 2011 intervention appears to be a sound and innovative approach to remind members about the importance of obtaining dental visits. The MCHP included all interventions started in 2009 and the projected intervention for 2012. They have built on past initiatives and have attempted to use what they learned from previous approaches to maintain a positive impact on members' behavior in obtaining their annual dental visit.

Sampling

No sampling was used in this study.

Data Analysis and Interpretation of Results

The study results are provided and were updated at the time of the on-site review. The data and analysis was completed by region. This analysis was complete and did correspond with the data analysis plan. The Central Region used HEDIS 2009 as the baseline data year. The Eastern and Western Regions baseline year was HEDIS 2011. The success of the project is determined by the demonstrated quantitative data reflecting an increase in the HEDIS ADV, and an increase in the HEDIS-like rolling 12-month administrative rate during each quarter of the study year. A graph of the MCHP's annual dental visit rate from 2003 through HEDIS 2012 was presented. This indicated a significant increase, particularly from HEDIS 2009 through HEDIS 2011, which resulted in a rate of 42.15%. This exceeded the 3% goal set out in the statewide project. The percentages for the baseline year and the two re-measurement years were presented. Statistical significance testing was completed. Factors that influenced the outcomes were presented, including outside factors that may have created some improvement on their own. The validity of the data is not in question. There is some question about the direct impact of the interventions. This is explained and considered in the overall analysis.

A detailed analysis was done for the results found in each region. Statistical significance testing was completed throughout the analysis. All of the yearly HEDIS rates indicate a significant

improvement in the MCHPs ADV rates. Missouri Care points out that they remain below the NCQA national average. The Central Region reports a baseline from 2009, when the HEDIS ADV rate was 27.41%. The HEDIS 2011 rate was 42.15%. Not only does this exceed the 3% improvement, but a significant increase has been achieved in each measurement year. The MCHP is now using 2011 as a new baseline year for a continued comparison with HEDIS 2012 and 2013. The HEDIS 2012 rate for the central region was 44.74%, and again showed a significant improvement of the previous year's rates. They believe that the current interventions are successful at impacting Missouri Care members' oral health.

A separate analysis was completed for the Eastern and Western Regions. In these regions the baseline was HEDIS 2011. The Eastern Region baseline rate was 29.04% and the Western Region baseline rate was 29.18%. There is only one remeasurement year, HEDIS 2012. The two regions HEDIS rates were 32.97% and 35.09% respectively. Each region exceeded their goal of a 3% increase. The rates have not achieved the success of the Central Region, but they have shown a significant increase.

The quarterly rolling 12-month HEDIS-Like ADV Rate have continued to see an overall increase in compliance with members obtaining their annual dental visit.

Assessment of Improvement Process

The narrative does include an analysis of the data, and a thoughtful interpretation of the effect of the interventions implemented on the outcome. A plan for follow-up activities and additional interpretation as new data becomes available is included. The PIP also outlines the interventions to be implemented in 2012. Missouri Care continues to measure the impact of the practices developed on a monthly, quarterly and annual basis. They utilize this data to plan and implement changes, which determines new interventions and approaches to solving problems. The MCHP believes that other normal processes do influence the ADV rate. They admit that the interventions implemented throughout this PIP have greatly contributed to the success achieved to date.

Conclusion

Although Missouri Care has achieved success in making the 3% improvements set as the standard in the statewide initiative, they have not achieved the goal of reaching the NCQA HEDIS 75th percentile. They continue to implement new interventions, and to track and trend their initiatives so additional improvement can be achieved. It is apparent that Missouri Care uses the PIP process as a method to obtain their improved performance. The process helps them to define issues. They also use it to develop and implement changes in organizational operations that create an atmosphere for growth and continuous quality improvement.

CONCLUSIONS

QUALITY OF CARE

The issue of quality was a primary focus of the two PIPs undertaken by Missouri Care. The quality of health care, and the overarching issue of the quality of life of MCHP members, were both addressed in these PIPs. Enacting measures to decrease the use of emergency departments by educating and informing members about the importance of developing a relationship with the PCP enhances those members quality of care. Both PIPs used this process to provide opportunities for primary preventive care enhancing the quality of services received by members. In both projects the MCHP stated their planned intention to incorporate these interventions into normal daily operations as the data indicates positive outcomes. Undertaking performance improvement projects that will develop into enhanced service programs for members indicates a commitment to quality service delivery.

ACCESS TO CARE

The study topics presented in these PIPS addressed issues that will create improved services and enhanced access to care for MCHP members. Although these PIPs overlapped in the area of discouraging emergency department utilization for dental issues, they did create a potential for improved access to appropriate services. Missouri Care changed dental subcontractors, and then actively engaged the new vendor in enhancing members' access to dental services. Utilizing

a mobile dental unit to reach underserved areas is a strong indicator of the MCHP's understanding of access as a problem, and a creative member focused approach to problem resolution.

TIMELINESS OF CARE

A major focus of these performance improvement projects was ensuring that members had timely access to care. Implementing strategies to ensure that members obtain important health care interventions in a timely manner continues to positively impact timely access to care. The projects indicate that the MCHP has a commitment to assisting members in engaging in timely treatment. By working with providers to encourage patients to make timely appointments for themselves and their children enables better health care outcomes.

RECOMMENDATIONS

1. Continue to utilize the protocols to develop and evaluate performance improvement studies. The quality of the studies submitted continues to improve. Both studies provide evidence that there was thought and consideration put into planning these studies, developing appropriate interventions, and creating a positive environment for the potential outcomes. This process will also ensure that as the studies are completed, effective data collection and analysis will occur.
2. Ensure that each PIP employs interventions pertinent to that study. The dental PIP indicated positive results. The ED PIP did not initially achieve the results desired. The lack of focused interventions could have resulted in less than desired outcomes.
3. Continue the process of looking at Missouri Care statistics and data to analyze the best use of resources in creating performance improvement initiatives. This internal research is clear evidence of the MCHP's commitment to quality member service.
4. Develop a process for evaluating the conclusions in the projects. Whether interventions are successful or not, draw conclusions based on the data. If an intervention does not achieve the desired result, include information about what happened and why.
5. Continue to utilize a creative approach to developing projects and interventions that will produce positive outcomes. Ensure that there is adequate documentation to explain the impact of the interventions on the findings and outcomes.

10.2 Validation of Performance Measures

METHODS

Objectives, technical methods, and procedures are described under separate cover. This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for MO Care. MO Care submitted the requested documents on or before the due date of February 20, 2012. The EQRO reviewed documentation between February 20, 2012 and June 15, 2012. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The NCQA RoadMap submitted by MO Care
- MEDSTAT's NCQA HEDIS Compliance Audit Report for 2011
- MO Care's HEDIS Data Entry Training Manual
- MO Care's Policies pertaining to HEDIS rate calculation and reporting

The following are the data files submitted for review by the EQRO:

- ADV_FILE_1.txt
- ADV_FILE_2.txt
- CIS_FILE_1.txt
- CIS_FILE_2.txt
- CIS_FILE_3.txt
- FUH_FILE_1.txt
- FUH_FILE_2.txt

INTERVIEWS

The EQRO conducted on-site interviews in Columbia, MO on Monday, June 18, 2012 with the MO Care staff that were responsible for the process of calculating the HEDIS 2011 performance measures. The objective of the on-site visit was to verify the methods and processes behind the calculation of the three HEDIS performance measures. This included both manual and automatic processes of information collection, storing, analyzing and reporting.

FINDINGS

MO Care calculated the Follow-Up After Hospitalization for Mental Illness and Annual Dental Visit measures using the administrative method. The hybrid method was used to calculate the Childhood Immunizations Status measure.

MCHP to MCHP comparisons of the rates of Childhood Immunizations Status, Follow-Up After Hospitalization for Mental Illness, and Annual Dental Visit measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The reported rate for MO Care for the Annual Dental Visit rate was 41.34%; this was comparable to the statewide rate for all MCHPs (41.84%, $z = 0.24$; 95% CI: 36.11%, 46.57%; n.s.). This rate was a substantial **increase** over the rates reported in the 2007, 2008, 2009, and 2010 EQR report years (27.26%, 27.50%, 27.41% and 38.21% respectively; see Table 41 and Figure 44).

The HEDIS 2011 rate for MO Care for the Childhood Immunizations Status measure was 64.14%, which was **significantly higher** than the statewide rate for all MCHPs (57.47%; $z = 1.09$, 95% CI: 59.19%, 69.09%; $p > .95$). This is the first year the EQRO has audited the Childhood Immunizations Status Combination 3 measure, and therefore no data is available for trend analysis.

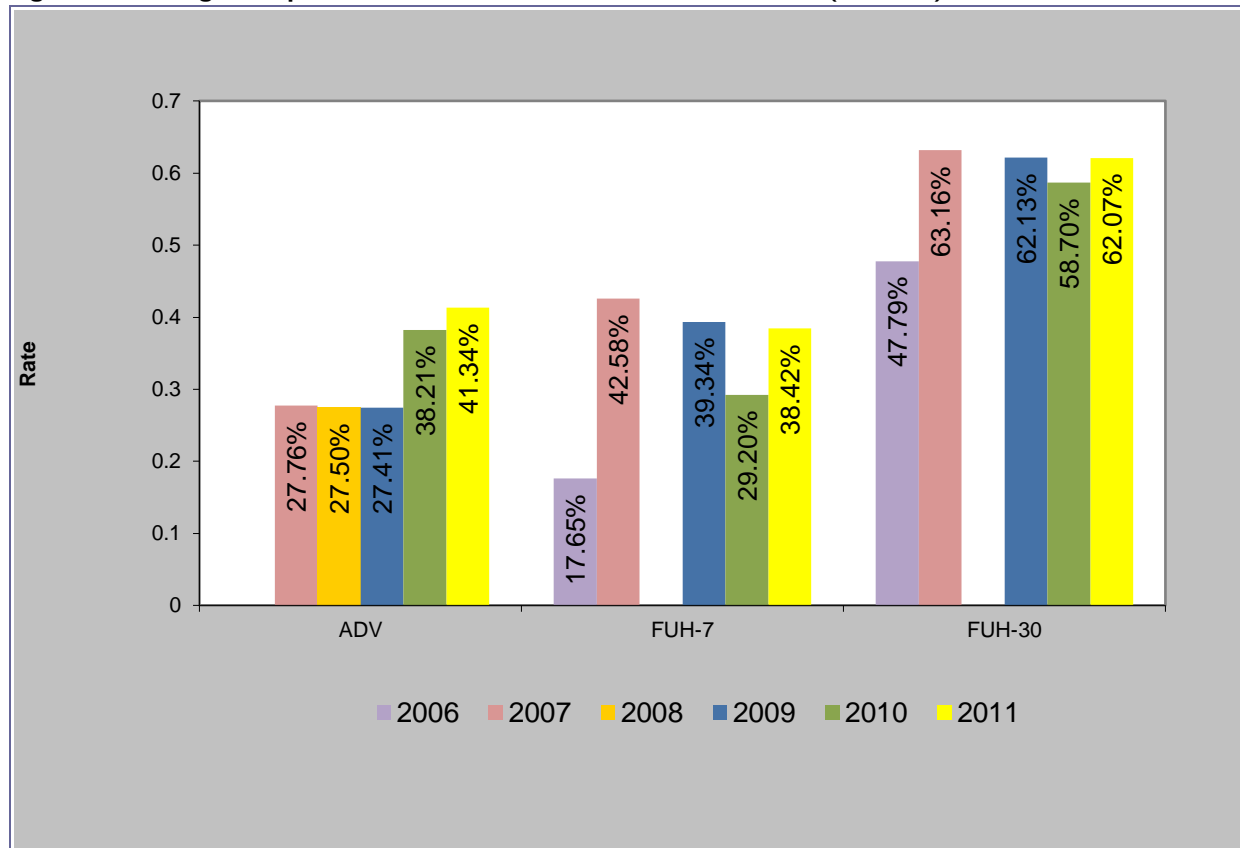
The Follow-Up After Hospitalization for Mental Illness measure 7-day rate reported to the SMA and the State Public Health Agency (SPHA) by MO Care was 38.42%. The rate reported was **significantly lower** than the statewide rate for all MCHPs (45.61%; $z = -0.60$, 95% CI: 31.85%, 44.99%; $p < .05$). The rate was **higher** than the rates of 17.65% and 29.20% reported in 2006 and 2010 respectively, but shows a **decrease** from the rates reported in the 2007 and 2009 audit years (42.58% and 39.34%, respectively). The 30-day reported rate was 62.07%, which was comparable to the statewide rate for all MCHPs (66.22%; $z = 2.28$, 95% CI: 55.50%, 68.64%; n.s.). This rate was **higher** than the rates reported in 2006, 2009, and 2010 (47.79%, 62.13% and 58.07%, respectively), but slightly **lower** than the rate (63.16%) reported for the HEDIS 2007 audit (see Table 41 and Figure 44).

Table 41 – Reported Performance Measures Rates Across Audit Years (MOCare)

Measure	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	HEDIS 2009 Rate	HEDIS 2010 Rate	HEDIS 2011 Rate
Annual Dental Visit (ADV)	NA	27.76%	27.50%	27.41%	38.21%	41.34%
Childhood Immunizations Status – Combination 3 (CIS3)	NA	NA	NA	NA	NA	64.14%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	17.65%	42.58%	NA	39.34%	29.20%	38.42%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	47.79%	63.16%	NA	62.13%	58.70%	62.07%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year

Figure 44 – Change in Reported Performance Measure Rates Over Time (MOCare)



Sources: BHC, Inc. 2006-2011 External Quality Review Performance Measure Validation Reports

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the main report for activities, ratings, and comments related to the CMS Protocol Attachments.

DATA INTEGRATION AND CONTROL

The information systems (IS) management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. For all three measures, MO Care was found to meet all criteria for producing complete and accurate data. There were no biases or errors found in the manner in which MO Care transferred data into the repository used for calculating the HEDIS 2011 measures.

DOCUMENTATION OF DATA AND PROCESSES

MO Care used Catalyst, an NCQA-certified software program in the calculation of the HEDIS 2011 performance measures. The EQRO was provided a demonstration of this software, as well as appropriate documentation of the processes and methods used by this software package in the calculation of rates. The EQRO was also provided with an overview of the data flow and integration mechanisms for external databases for these measures. Data and processes used for the calculation of measures were adequate. MO Care met all criteria that applied for all three measures.

PROCESSES USED TO PRODUCE DENOMINATORS

MO Care met all criteria for the processes employed to produce the denominators of all three performance measures. This involved the selection of members eligible for the services being measured.

For the HEDIS 2011 Annual Dental Visit measure, there were a total of 24,371 eligible members reported and validated by the EQRO.

For the HEDIS 2011 Childhood Immunizations Status measure, there were a total of 1,821 eligible members listed by the MCHP and validated by the EQRO. The samples taken for medical record review were within the specified range and allowable methods for proper sampling.

For the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure, a total of 406 eligible members were identified and validated.

PROCESSES USED TO PRODUCE NUMERATORS

All three measures included the appropriate data ranges for the qualifying events (e.g., well-care visits, medication dispensing events, and dental visits) as specified by the HEDIS 2011 criteria. A medical record review was conducted for the Childhood Immunizations Status measure.

For the HEDIS 2011 Annual Dental Visit measure, the EQRO validated 10,058 of the 10,075 reported administrative hits. The MCHP's reported rate was 41.34% and the EQRO validated rate was 41.27%, showing a bias (overestimation) by the MCHP of 0.07%.

For the Childhood Immunizations Status measure, MO Care reported 646 administrative hits; the EQRO validation showed 644 hits. For the medical record review validation, the EQRO requested 30 records. A total of 30 records were received for review, and all 30 of those were validated by the EQRO. Therefore, the percentage of medical records validated by the EQRO was 100.00%. The rate calculated by the EQRO based on validated administrative and hybrid hits was 64.14%, while the rate reported by the MCHP was 63.92%. This represents a bias of 0.22%, an overestimate by the MCHP for this measure.

For the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure 7-day rate, the MCHP reported 156 administrative hits from the eligible population; the EQRO was able to validate all 156 of these hits. The reported and validated rates were therefore 38.42%, with no observed bias.

The 30-day rate showed the reported number of administrative hits as 252; the EQRO validated 252 hits. This represents a reported rate of 62.07% as well as a validated rate of 62.07%, again showing no bias for this measure.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Childhood Immunizations Status measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure.

SUBMISSION OF MEASURES TO THE STATE

MO Care submitted the Data Submission Tool (DST) for each of the three measures validated to the SPHA (the Missouri Department of Health and Senior Services; DHSS) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS

The following table shows the estimated bias and the direction of bias found by the EQRO. The Childhood Immunizations Status and Annual Dental Visit measures showed slight overestimates, but all results fell within the 95% confidence interval reported by the MCHP for these measures. The Follow-Up After Hospitalization for Mental Illness measures was Fully Compliant.

Table 42 - Estimate of Bias in Reporting of MOCare HEDIS 2011 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	0.07%	Overestimate
Childhood Immunizations Status (Combination 3)	0.22%	Overestimate
Follow-Up After Hospitalization for Mental Illness (7-day)	No bias	N/A
Follow-Up After Hospitalization for Mental Illness (30-day)	No bias	N/A

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure. The following table summarizes Final Audit Ratings based on the Attachments and validation of numerators and denominators.

Table 43 - Final Audit Rating for MOCare Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Substantially Compliant
Childhood Immunizations Status	Substantially Compliant
Follow-Up After Hospitalization for Mental Illness	Fully Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCHP. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No Managed Care Members qualified for the measure.

CONCLUSIONS

Three rates were validated for the MCHP. The Childhood Immunizations Status rate was **significantly higher** than the average for all MCHPs, the Follow-Up After Hospitalization rate was **significantly lower** or consistent with the average for all MCHPs, and the Annual Dental rate was consistent with the average for all MCHPs.

QUALITY OF CARE

MO Care's calculation of the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure was fully compliant with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered.

The MCHP's 7-day rate for this measure was **significantly lower** than the average for all MCHPs. Therefore, MO Care's members are receiving a **lower** quality of care for this measure than the average MCHP member in the 7-day timeframe. The 30-day rate was consistent with the average for all MCHPs, indicating MO Care's members are receiving the same quality of care as the average MCHP member in the 30-day timeframe.

Both the 7-day and 30-day rates were **lower** than both the National Medicaid and National Commercial averages; the MCHP's members are receiving a **lower** quality of care than the average Medicaid or Commercial member across the country. However, both the 7-day and

30-day rates are **higher** than the rates reported in the HEDIS 2010 audit, indicating the quality of care to members as risen over the past measurement year.

ACCESS TO CARE

The HEDIS 2011 Annual Dental Measure for MO Care was substantially compliant with specifications; this measure is categorized as an Access/Availability of Care measure. Because only one visit is required for a positive “hit”, this measure effectively demonstrates the level of access to care that members are receiving.

The rate reported by the MCHP for this measure was consistent with the average for all MCHPs. Therefore, MO Care’s members are receiving a quality of care for this measure that is on level with the average Managed Care member. This rate was **lower** than the National Medicaid rate for this same measure, indicating the MCHP’s members are receiving a **lower** access to care than the average Medicaid member across the nation. However, while the rate had continued to fall from 2007-2009, the last two HEDIS audit years (2010 and 2011) have showed substantial improvement, indicating an improved access to care for MO Care members.

TIMELINESS OF CARE

The MCHP’s calculation of the HEDIS 2011 Childhood Immunizations Status measure was substantially compliant with specifications. This measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received.

The MCHP’s reported rate for this measure was **significantly higher** than the average for all MCHPs. Therefore, MO Care’s members are receiving a **higher** timeliness of care for this measure than the care delivered to the average Managed Care member.

The rate was **lower** than both the National Medicaid and National Commercial averages; the MCHP’s members are receiving Childhood Immunizations in a manner **less** timely than the average Medicaid or Commercial member across the country.

RECOMMENDATIONS

1. The MCHP's rate for the Annual Dental Visit measure has risen substantially in the last two review periods. The MCHP should continue the programs implemented that have helped to reverse the previously seen downward-trend in this measure.
2. Continue to conduct and document statistical comparisons on rates from year to year.
3. Continue to participate in training of MCHP staff involved in the oversight of coordination of performance measure calculation.
4. Continue to perform hybrid measurement on those measures that are available for this method of calculation.
5. The downward trends previously seen in both the 7-day and 30-day Follow Up After Hospitalization for Mental Illness measure seem to have been reversed according to the most recent audit results. The EQRO recommends that the MCHP continue to focus on the interventions that seem to be reversing this trend in rates.

10.3 MCHP Compliance with Managed Care Regulations

METHODS

Missouri Care (MO Care) was subject to a follow up compliance audit during this on-site review. The content of this 2011 calendar year audit will include all components of the Quality Standards as defined in 42 CFR 438. Evaluation of these components included review of:

- Defined organizational structure with corresponding committee minutes
- Policies and Procedures
- Organizational protocols
- Print materials available to members and providers
- Report results
- Staff interviews

The Team utilized an administrative review tool which was developed based on the CMS Protocol Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient MCHPs (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Regulations (Compliance Protocol). The evaluation included review of MCCI's compliance with Access Standards, Structure and Operations Standards, and Measurement and Improvement Standards. Utilizing these tools, MO Care will be evaluated on the timeliness, access, and quality of care provided. This report will then incorporate a discussion of the MCHP's strengths and weaknesses with recommendations for improvement to enhance overall performance and compliance with standards.

The EQRO rating scale remains as it was during the last evaluation period.

M = Met

Documentation supports that all components were implemented, reviewed, revised, and/or further developed.

PM = Partially Met

Documentation supports some but not all components were present.

N = Not Met

No documentation found to substantiate this component.

N/A = Not Applicable.

Component is not applicable to the focus of the evaluation. N/A scores will be adjusted for the scoring denominators and numerators.

A summary for compliance for all evaluated Quality Standards is included in Table 44.

Table 44 - Comparison of MO Care Compliance Ratings for Compliance Review Years (2009, 2010, 2011)

Measure	2009	2010	2011
<i>Enrollee Rights and Protections</i>	100%	100%	100%
<i>Access and Availability</i>	100%	76.5%	82.35%
<i>Structure and Operations</i>	100%	100%	100%
<i>Measurement and Improvement</i>	100%	100%	90.90%
<i>Grievance Systems</i>	100%	88.9%	100%

Description of the Data:

The review of Quality Standards was completed using a Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations.

FINDINGS

Enrollee Rights and Protections

Enrollee Rights and Protections address 13 standards. For the 2011 review, Missouri Care was rated by the review team to have met all 13 standards. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2009 and 2010.

Missouri Care continues to participate in community-based programs throughout all three Managed Care regions. They were involved in school-based health clinics whenever possible. The MCHP participated in a back-to-school fair where they not only contacted member families directly, but were able to network with regional primary care physicians (PCPs). Additionally, outreach calls were made to all eligible children. A quarterly newsletter for school nurses was developed and continues to be distributed by the MCHP.

The rating for Enrollee Rights and Protections (100%) reflects that the MCHP complied with the submission and approval of all policy and procedures to the SMA. All practice observed at the

on-site review indicated that the MCHP appears to be fully compliant with Medicaid Managed Care Contract requirements and federal regulations in this area.

Access Standards

Access and Availability addresses 17 standards. For the 2011 review, MO Care was rated by the review team to have met 14 standards. This is an overall rating of 82.35%, which is an improvement over the rating of 76.5% received in 2010, but is still a decrease from the 2009 rate of 100%.

The MCHP continues to work to develop new and additional resources for their members. The Missouri Care network includes Kansas City Children's Mercy Hospital, St. Louis Children's Hospital, and the University of Missouri Health Care System. These resources make specialties, such as orthopedic services accessible to members. Pediatric cardiology and neurology are available at the University of Missouri Hospital and Clinics.

The rating regarding Compliance with Access Standards regulations is (82.35%). Missouri Care submitted required policy and procedures to the SMA for their approval. However, in reviewing records and interviewing staff, full evidence of assessments and treatment planning for members was not available. During the on-site review the commitment to good case management practice was observed.

Structures and Operation Standards

The area of Structures and Operations addresses 10 standards. For the 2011 review, MO Care was rated by the review team to have met all 10 standards. This is an overall rating of 100% compliance, which is consistent with the ratings received in 2009 and 2010. The ratings for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the sixth year. The MCHP submitted all required policy for approval, and all practice observed at the time of the on-site review indicated compliance in this area. All credentialing policy and practice was in place. All disenrollment policy was complete and all subcontractor requirements were met.

During the 2011 Calendar Year, the MCHP became NCQA accredited and continues to follow NCQA standards regarding credentialing. All credentialing performed by Missouri Care meets NCQA standards and complies with federal and state regulations, and the SMA contract requirements. Re-credentialing is completed at three-year intervals, and delegated entities are monitored annually. State and federal sanctions are monitored monthly using the HHS OIG/OPM (Office of Inspector General/Office of Personnel Management) web site. The MCHP does monitor the subcontractors, detailed histories, problem resolution, and performance improvement are reviewed each year.

Measurement and Improvement

Measurement and Improvement addresses 12 standards. For the 2011 review, Missouri Care was rated by the review team to have met 10 standards; one standard was “Partially Met”; and one standard was found to be Not Applicable. This is an overall rating of 90.90% compliance, which is a **decrease** from the 100% ratings received in 2009 and 2010.

Missouri Care continues to operate a Quality Management Oversight Committee made up of the Chief Executive Officer, Plan Administrator, Chief Medical Officer, and department managers. The goal of this group was to provide oversight of all operations and MCHP initiatives.

The MCHP did submit two Performance Improvement Projects (PIPs), which included enough information to complete validation, however the quality of one of the PIPs was **lower** than the quality observed during prior reviews. All Performance Measurement data and medical records requested were submitted for validation within requested timeframes. Missouri Care also submitted all required encounter data in the format requested. The specific details can be found in the appropriate sections of this report.

The rating for the Measurement and Improvement section (90.90%) reflects that all required policy and procedure had been submitted to the SMA for their approval. It appeared that all practice observed at the time of the on-site review met the requirements of the Managed Care contract and the federal regulations.

Grievance Systems

Grievance Systems addresses 18 standards. For the 2011 review, Missouri Care was rated by the review team to have met all 18 standards. This is an overall rating of 100% compliance, which is **higher** than the rating received in 2010 (88.9%) and **consistent with** the 100% rating received in 2009.

Review of Grievance and Appeals Files

The EQRO reviewed grievance and appeals files while on-site at Missouri Care on Monday, June 18, 2012. The EQRO Project Director, Amy McCurry Schwartz, read 40 files and completed an analysis tool for each file reviewed. These files were reviewed for compliance with Federal Regulations and the MCHP's State Contract. The table below summarizes the findings of this file review.

Table 45 – Compliance File Review, MO Care

MCHP	# of records reviewed	# with issue	% with issues	% Correct
MO Care	40	0	0.00%	100.0%

MO Care showed **improvement** in this area of the review, in 2010 the MCHP received a rating of 85.71% correct in the Grievance and Appeals File review in contrast to the 2011 rating of 100% correct.

Although not specifically attributable to this MCHP, it is noted that the mandatory language required by the State of Missouri in all Notice of Action letters is considered confusing by the EQRO. The language contained in the clause related to the member's right to "Continuation of Services" and the requirement to list all legal aid offices in the State of Missouri and not the one specific to the member's address both serve to make the letter confusing.

State Inquiry Log review

The EQRO also reviewed the MCHP's response to any "inquiries" received by the SMA during the fourth quarter of Calendar year 2011 that pertained to a Missouri Care member. Missouri Care has a specific procedure in place for dealing with "State Inquiries". The MCHP keeps a "Master List of Regulatory Inquiries and Responses". This is an Excel spreadsheet where any inquiries are logged and responses to these inquiries are recorded. Missouri Care made

information from the “Master List” available to the EQR team of all the State Inquiries that were received. Of the 15 inquiries that the EQR was asked to review, one inquiry resulted in an expedited appeal. All other inquiries were handled by the appropriate MO Care staff and the resolution was logged in the “Master List”. The EQR team felt that these were handled appropriately.

Ratings for compliance with the Grievance Systems regulations (100%) indicate that the MCHP completed all of the requirements regarding policy and practice. This is the sixth out of seven years that the MCHP is fully compliant in this section of the review.

CONCLUSIONS

Missouri Care continues to maintain compliance in all areas of policy, procedure, and practice required by the Managed Care contract and the federal regulations. The MCHP utilizes a proactive approach to identifying issues discussed in previous External Quality Reviews, internal monitoring, and its Quality Improvement program to ensure that required written materials were submitted to the SMA in a timely and efficient manner.

The staff at Missouri Care exhibits a commitment to quality and integrity in their work with members. The MCHP utilizes unique processes, such as bringing the provision of behavioral health services into the organization, as a method for improving the access, quality and timeliness of member services. They are committed to this integrated approach where case managers utilize the areas of expertise of their team members, yet provide individualized services to members to eliminate confusion. Missouri Care has created tools to educate and inform the community and providers.

However, a few issues were identified during this year’s review, including:

- Missing treatment plans and assessments from Case Management files.
- Quality was lacking in one Performance Improvement Project.

QUALITY OF CARE

Quality of care is a priority for Missouri Care. Their attention to internal and external problem solving, supporting and monitoring providers, and participation in community initiatives are evidence of the commitment to quality healthcare. They are making a concerted effort to extend this approach to all three Managed Care regions. Missouri Care completed all policy requirements and has put processes in place to ensure that procedures and practices follow approved policy requirements. A commitment to obtaining quality service for members is evident in interviews with MCHP staff, who express enthusiasm for their roles in producing sound healthcare for their members.

However, missing assessments and treatment plans in Case Management files indicates that an improvement can be made in this area to ensure that the evidence exists to support that the quality of care received by members in Case Management matches that delivered in other areas of the organization.

ACCESS TO CARE

Missouri Care has made concerted efforts to ensure that members throughout their Managed Care Regions have adequate access to care. They have recruited additional hospitals and individual providers into their network. The MCHP has participated in community events to promote preventive care and to ensure that members are aware of available services. The MCHP exhibits an awareness and commitment to resolving issues that are barriers to member services.

TIMELINESS OF CARE

Missouri Care has developed procedures to ensure that policy is submitted in a timely manner and that all tracking tools are up-to-date. They are utilizing greatly improved case management software and systems tools to have the most accurate and up-to-date information available on members to support them in obtaining appropriate healthcare services in a timely manner. The MCHP has engaged in a number of activities to ensure that organizational processes support the delivery of timely and quality healthcare.

RECOMMENDATIONS

1. Make every effort to supply the EQRO with all relevant information for every case file, grievance file, policy or procedure requested. The lack of information that was provided to the reviewers explains many of MO Care's **lower** rates in this year's review.
2. Supply training regarding contract requirements to the Grievance/Appeals staff to ensure compliance with all timelines and content standards.
3. Show all Performance Improvement Projects the level of commitment that has been granted in the past, successful PIPs can drive the MCHP's future.
4. Continue monitoring access to dental care and assist in recruitment of providers throughout all Regions.
5. Continue to develop and improve the multi-disciplinary approach to working with members that have complex health care issues.

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11.0 Molina Healthcare of Missouri

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11.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Molina HealthCare of Missouri supplied documentation for review of two Performance Improvement Projects.

- Reducing Repeat Emergency Department Visits for Members with Asthma
- Statewide Performance Improvement Project – Improving Adolescent Well-Care Molina HealthCare of Missouri

INTERVIEWS

Interviews were scheduled during the on-site review to be held on June 29, 2012. The EQRO was denied access to the facility or personnel by Molina administrators. The results of these PIPs are based on their original submission. The MCHP was informed that they could provide additional or updated data up to the time of the scheduled on-site review. No updated or additional data was received.

FINDINGS

CLINICAL PIP – REDUCING REPEAT EMERGENCY DEPARTMENT VISITS FOR MEMBERS WITH ASTHMA

Study Topic

The first PIP evaluated was titled “Reducing Repeat Emergency Department Visits for Members with Asthma.” This PIP was submitted as a clinical Performance Improvement Project. The documentation indicated that Molina’s goal was to “empower members and their parents with knowledge that will help them to improve their control of asthma, reducing acute exacerbations that result in a trip to the emergency department for stabilization.” The study topic was well documented and supported the need to confront this issue as a method to improve the services members receive. Both national and local statistics were used to highlight the need for asthma

interventions to prevent acute illness. The overarching goal is to avoid the emergency room whenever possible, and to ensure that members had the information necessary to obtain the correct service in the correct setting.

The specific focus of this PIP was on empowering members to control their own health care. The MCHP hoped to identify and correct current deficiencies in available health services. The hoped for effect is to prevent the need for emergency room care by providing members with the information needed so they are able to obtain more convenient and comprehensive health care. Molina hopes that this will occur by connecting members with their PCP and required specialists. The concept is presented with background concerning MCHP members. A strong argument is presented for addressing this problem. The population to be served included all members with asthma, and then focused interventions on those with recent emergency room visits. The study topic justification was presented in a thorough and competent manner. The research review and statistical analysis supporting this decision were well presented.

Study Question

The study question presented is:

“Will in-home member education and health care visits provided to members with asthma, who have had a recent asthma related emergency department visit, reduce the number of repeat asthma-related emergency department visits?”

The study question is focused and measureable. The goal of the study is clear.

Study Indicators

The study indicators are:

- 1) The number of members identified as participants in MedStaff Asthma and Education Outreach;
- 2) Repeat emergency room visits at 30, 90, and 180 days; and
- 3) The number of members with repeat emergency room visits after receiving MedStaff asthma outreach and education.

An explanation is provided for each indicator. The comparison will be made after the emergency room visits are counted, and compared to the member receiving case management. The way in which these indicators will be used, and how they are counted and tracked is vague. There was an explanation included regarding each indicator. Questions remained about how individual members were tracked and how new members were included in the statistics. The

population of members who go to the emergency room with an asthma related illness could perceivably change on an on-going basis. There was no information provided about time frames, or who is included in the study, or how this is tracked and trended on a continuous basis.

Study Population

The population for the PIP included all MCHP members seen in emergency departments of network participating hospitals with claims data indicating an asthma diagnosis code, ICD-9 coded 493.0 through 493.9 as a primary or secondary diagnosis, indicative of an asthma-related encounter will be included in the study.

Sampling

The information provided explains that Molina will use non-probability, convenience sampling. The MCHP approached their network hospitals in the St. Louis area. They chose hospitals with high utilization and requested a partnership to create a daily report identifying those members who were seen in the ED and discharged home. The hospitals able to support the data request are included in this PIP. The documentation did not explain who is excluded.

The daily reports received from the included hospitals supplies the member's name, date of birth, DCN, and demographics. These reports are the source documents identifying members to include in the convenience sample. This information provided data so the case management services were initiated immediately, eliminating the delay of waiting for claims data. The documentation did not indicate if the sample number (15,594 members) was a significant percentage of the regional population, or the total population with asthma. Some discrepancies existed in the original information provided. As the EQRO team was denied access to the MCHP, it was not possible to ask questions or obtain clarification of the information presented.

Study Design and Data Collection Procedure

The documentation includes conflicting information. In the "Indicators" section the MCHP states that members are included by identifying those who have had an emergency department visit, in the "monthly claims data." In the Sampling section Missouri Care espouses that it will use hospital generated reports to avoid the delay caused by using the claims data. These two reports may be used differently. This is not clear in the information presented. This section of the report also discusses "all members who have been seen in the ED." The Sampling section

discusses members from specific St. Louis based hospitals. These discrepancies create confusion about who will be studied, and how the data is collected and used.

The MCHP narrative identifies the source of data as the QNXT claims reporting system – to be queried monthly. The narrative states they are looking for ED Claims, Home Health authorizations, and Home Health Claims. This section never discussed how the sampling will be integrated into the study. The sections of the study design that should provide information on a systematic method for collecting valid and reliable data, and that provides assurances that there is consistent and accurate data collection over time are vague and lack detail. There are many questions about how the data will be obtained, how individual members will be tracked, and how conclusions will be developed. No answers to these questions were available.

The documentation received did not include a prospective data analysis plan. The name of only one staff member was included in the study design information. No roles or responsibilities were included.

Improvement Strategies

The planned Improvement Strategies were:

- A minimum of 3 home visits from MedStaff Home Health for any member seen at the select hospitals.

The initial intervention is explained and details are provided about what activities are to occur at each in-home contact. There is no information provided about why this approach was chosen, or why the MCHP is convinced that this will be the most effective approach with these members. Toward the end of this section of the documentation, the MCHP did include a paragraph that states that they will evaluate the data obtained from the MedStaff Home Health visits. They will track and trend the information obtained to ensure that the education provided is effective. This is to occur quarterly. The documentation ensures the reader that there is adequate goal setting. The family's goals or hoped for interventions are not explicit.

Data Analysis and Interpretation of Study Results

The documentation states that data analysis will occur bi-annually. The information, which would have been available included the period from July 1, 2011 through December 31, 2011.

This was not complete as the result of the “claims lag for both emergency department and home health claims.” It was not updated.

Tables and graphs were presented for the members receiving services. Comparisons were attempted with study and non-study hospitals. The information presented is confusing and it is difficult to interpret. The analysis presented needs clarification. It was difficult to evaluate based on the information available. An example is that the narrative mentions that the claims data indicated a different number than the ED Census Report. This is not explored or explained. The analysis occurred with very little data. Although the narrative tries to draw conclusions and analyze the data available, it seems like a disservice to the study. The data analysis did not look at any baseline so again, comparisons are difficult to understand.

Assess Improvement Process

The documentation asserts that Missouri Care has created an improved method of treating members with asthma, even based on the limited information available. They also recognized opportunities for additional interventions. Although the data does indicate that there might be a correlation between the intervention implemented and reductions in hospitalizations or ED visits by members with asthma, it is difficult to validate this due to the length of time this PIP was in process and the limited data available,

Conclusion

It appears that this in-home case management approach to intervene with these members is a sound strategy. However, it is not validated in this information provided. The PIP must be supported by understandable narrative, and convincing data. It is never clear which members are being discussed – in some places the narrative discusses “all members,” and in others it is appears that just the sample population is used. Clarification within the narrative and a better use of updated data are required to provide confidence that this approach has a direct impact on the identified problem. Participation in the on-site interviews with EQR staff would have insured that the MCHP was able to provide clarification to these questions. Molina’ refusal to participate in the on-site review is the reason for their lower than average ratings.

NON-CLINICAL PIP – IMPROVING ORAL HEALTH

Study Topic

The second PIP evaluated was the Molina HealthCare of Missouri individualized approach to the Statewide PIP “Improving Oral Health.” This is a non-clinical project. The decision to choose the study topic was supported by information provided regarding the MO HealthNet Managed Care Statewide PIP documentation. The narrative documented the importance of the topic and its relationship to the population served by the MCHP. The documentation discussed the resources that might be most helpful in creating the desired outcomes. The narrative presented describes how this subject is relevant to Molina HealthCare of Missouri members.

Study Question

The study question stated by Molina is:

“Will providing interventions to MO HealthNet Managed Care eligible members from the ages of 2 through 20 years old increase the number of children who receive an annual dental visit by 3% between HEDIS 2010 (data from calendar year 2009) and HEDIS 2012 (data from calendar year 2011)?”

The question formulates what is to occur and the desired outcome. The only update from the previous PIP is the change in the HEDIS year.

Study Indicator

The identified indicator is the Molina HEDIS rate for the Annual Dental Visits. The MCHP narrative states this clearly and concisely. It refers to the technical specifications as stated in the MCHP information. The denominator and numerator are presented. The data to be analyzed is specific and understandable. The narrative does not describe any monthly or quarterly measures to be researched. This PIP presentation focuses directly on children receiving annual dental visits. How the improvement will be tracked and measured is presented.

Study Population

The population to be served includes children ages 2 through 20. The PIP is designed to capture all eligible enrollees. The data to be used is explained. The system to be utilized to gather HEDIS data is defined.

Sampling

There is no sampling used in this study.

Study Design and Data Collection Procedures

The study design was not presented in great detail. It did describe the method used by DentaQuest to submit data to Molina. How the systems communicate, store, and process this information was provided. The documentation presented does indicate the data to be collected and its sources. This includes claims information and the specific CPT and ICD9 codes. The QNXT system and the process for obtaining and validating HEDIS rates were presented. By adhering to the HEDIS technical specification and following the study design the MCHP will produce valid and reliable data for the applicable population. The methodology to generate this rate and the data are explained in the narrative. This portion of the documentation discusses data collection within the scope of the HEDIS specifications in great detail. The MCHP used their HEDIS validated rate, which is collected systematically. This process provides confidence that the data is accurate over time. There is narrative supporting this assertion. The PIP does not simply site HEDIS technical specifications assuming that this explains all aspects of the data collection process. The narrative provided information about all of the processes utilized by the MCHP to manage and analyze data. This included obtaining information through their subcontractor, DentaQuest.

A prospective data analysis plan is presented including those who participate in the analysis process. Potential barriers to data collection were described. Controls for these issues were detailed.

All PIP team members and their roles and responsibilities were presented. This included local and corporate team members.

Improvement Strategies

The PIP narrative did not specify any focused interventions. It stated that the MCHP supports interventions for improving oral health. The narrative mentions that Molina brochures include information about obtaining an annual dental visit. It mentions that outreach activities occurred and were “educational.” What this means was not included. The narrative states that the MCHP has the ability to generate reports that include members who have not received at least

one dental visit during the measurement year. It goes on to say that it sends these reports to DentaQuest “periodically.” The description mentions that DentaQuest can contact members to assist them with finding a dental provider. The MCHP also sends lists of members who were seen in the emergency room with dental issues, so DentaQuest can assist them in finding a provider.

None of these were set up as an intervention. They were not being tracked or measured. The MCHP provided no indication that they were actively taking steps to work with members to assist them in obtaining annual dental visits.

A paragraph was included stating that the Provider Representatives deliver the Missed Services Reports to PCPs. They hope that the PCP’s educate members on obtaining additional services during well child visits. This activity was not tracked, nor was the MCHP actively involved in working with PCPs to ensure that they are providing information regarding annual dental visits. Finally the narrative mentions that Molina’s Corporate HEDIS department uses the data analysis process to determine if the “rates are following a similar pattern as in previous year, or if there appears to be an error in the data.” The MCHP took no responsibility for actively trying to improve the ADV rate by intervening with members or providers.

Data Analysis and Interpretation of Study Results

The PIP narrative did present an analysis of the findings through 2010 (HEDIS 2011). This is presented clearly and in more detail than presented in the prospective data analysis plan. The information presented included a year to year comparison. Tables that were presented that were clear and understandable. Narrative was included to explain these findings. Information presented did include a comparison for each region.

The information presented included a chi-squared analysis that indicates a statistically significant improvement for the MCHP. The initial and repeat measurement periods and the percentage of improvement are documented. This section of the PIP documentation was well done.

The information presented does show that through calendar year 2010 the MCHP did exceed the goal of 3% for improvement in their ADV rate. The narrative also includes information on the MCHPs goal for improvement for HEDIS 2012. They indicate that their preliminary results

do show improvement, but no actual HEDIS 2012 rates were provided. The MCHP did not evaluate the effectiveness of any PIP activities in contributing to these outcomes. No follow-up activities were mentioned.

Assessment of Improvement Process

It is unclear, based on the information presented, whether Missouri Care has attained “real” or sustained improvement. The narrative concludes that the MCHP implemented interventions and improvement strategies that contributed to the improved dental rates. This is stated, but not explained. The MCHP did include information from the HEDIS 2011 (data from calendar year 2010) and their preliminary findings for HEDIS 2012. They were given additional time to submit this information, but did provide updates.

The MCHP included narrative that attributed their success to all of the interventions that were put in place. There was no actual measurement of any activities. No information was provided about interventions that were or were not successful.

Conclusion

The MCHP states that “year after year” they have achieved statistically significant increases. They believe that the efforts of many departments at Molina contributed to ensuring that the Annual Dental Visit rate improved. This occurred in the departments that work directly with members and those that work with providers. The MCHP also asserts that as a result of these efforts they will continue to sustain the improvements through their consistent messaging to members.

CONCLUSIONS

QUALITY OF CARE

The best care in the most appropriate environment is the focus of the first PIP. The interventions incorporated methods to ensure that members obtained the highest quality services needed to manage their asthma. There is evidence in the clinical PIP that the MCHP is utilizing this process to improve member services and provide the most effective services that enable members to improve and obtain quality health care.

In the second PIP the MCHP made an effort to improve information provided to members and providers to assist them in obtaining their annual dental visits, which will improve their overall health care. They did significantly improve their reportable HEDIS rate, which they attribute to member and provider education.

ACCESS TO CARE

The focus of the first PIP does address access to care, and made every effort to provide case management in the home for members who had previously used the emergency department to obtain primary care. The intention of the interventions is to ensure that members' have in-home services that provide good health care and education to improve members' quality and access to care. Ensuring that members know how to access services to prevent the need for unnecessary emergency room care, and using an in-home method of providing this services, greatly improves access to care.

The second PIP did create an improved focus on member access to care by providing education for members and providers. The narrative lacks detail about how this was achieved.

TIMELINESS OF CARE

The educational efforts of the first PIP were implemented to encourage members to engage in the best self-care possible. Members received in-home case management regularly to ensure that they had all the information necessary to obtain timely health care services to manage their asthma. The MCHP developed a cooperative effort with area hospitals to receive immediate notice of members who used the emergency department for asthma related issues. Although the data review needed clarification, the theory of providing in-home services to enhance members' knowledge and ability in obtaining needed services for a chronic illness has promise. Obtaining services quickly and efficiently was an essential component of this PIP.

In the second PIP the issue of timeliness was addressed through the educational efforts and contacts with non-compliant members utilizing both member and provider interventions.

Participation in the on-site interviews with EQR staff would have insured that the MCHP was able to provide clarification to these questions. Molina's refusal to participate in the on-site review is the reason for their lower than average ratings.

RECOMMENDATIONS

1. The study design of Performance Improvement Projects should link the questions, the interventions, and the proposed outcomes to determine whether or not an intervention was effective. Providing details of the interventions and linking these interventions to the outcomes is essential.
2. Use monthly and quarterly measurements to ensure that interventions are effective throughout the measurement year. This will provide information on the ongoing effects of the planned program. Data analysis should incorporate methods to ensure that any resulting change, or lack of change, was related to the intervention.
3. Provide enough narrative to ensure that the reader understands the problem, the proposed interventions, the desired goals and outcomes. How the data presented relates to all these issues and either supports program improvement, or is not effective. Narrative should also be provided to defend the conclusions and outcomes of the study. Making a statement alone does not provide convincing evidence.
4. Provide enough narrative to ensure that the reader understands the problem, the proposed interventions, the goals and outcomes hoped for, and how the data presented relates to all these issues and either supports program improvement, or is not effective.
5. Narrative should be provided to defend the conclusions and defined outcomes of the study. Making a statement alone does not provide convincing evidence.

11.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Molina Healthcare. Molina Healthcare submitted the requested documents on or before the due date of February 20, 2012. The EQRO reviewed documentation between February 20, 2012 and June 15, 2012. On-site review time would have been used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculations. However, Molina refused to participate in the on-site review process, and therefore none of the plan's systems could be validated for the calculation of performance measures.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The NCQA RoadMap submitted by Molina Healthcare for the 2011 HEDIS review year.
- Healthcare Research Associates' (HRA) HEDIS 2011 Compliance Audit Report
- NovaSys Health Network, LLC, policies and procedures related to the HEDIS rate calculation process.
- NovaSys Health Network, Molina Healthcare electronic eligibility process
- Data files from the HEDIS repository containing eligible population, numerators and denominators for each of the three measures
- Decision rules & queries in the HEDIS 2011 repository used to identify eligible population, numerators and denominators for each of the three measures
- Query result files from the repository

The following are the data files submitted by Molina Healthcare for review by the EQRO:

- File 1 - ADV Central.txt
- File 1 - ADV Eastern.txt
- File 1 - ADV Western.txt
- File 1 - CIS Central.txt
- File 1 - CIS Eastern.txt
- File 1 - CIS Western.txt

- File 1 - FUH Central.txt
- File 1 - FUH Eastern.txt
- File 1 - FUH Western.txt
- File 2 - ADV Central.txt
- File 2 - ADV Eastern.txt
- File 2 - ADV Western.txt
- File 2 - CIS Central.txt
- File 2 - CIS Eastern.txt
- File 2 - CIS Western.txt
- File 2 - FUH Central.txt
- File 2 - FUH Eastern.txt
- File 2 - FUH Western.txt
- File 3 - CIS Central.txt
- File 3 - CIS Eastern.txt
- File 3 - CIS Western.txt

INTERVIEWS

Interviews were scheduled for Monday, July 25, 2012 at Molina Healthcare of Missouri's offices in St. Louis, MO. Upon arrival at Molina's offices, EQR team was met in the lobby and informed that Molina would not participate in any part of the on-site review. Therefore, no interviews were conducted with Molina staff during the scheduled interview time.

FINDINGS

The Administrative Method of calculation was used by Molina for the Follow-Up After Hospitalization for Mental Illness and Annual Dental Visit measures. The Hybrid Method was used for the calculation of the Adolescent Well-Care Visit measure. Molina did not participate in the On-Site visit process, and therefore, the calculation methods and system could not be verified. However, assuming their system is valid, MCHP toMCHP comparisons of the rates of Follow-Up After Hospitalization for Mental Illness, Adolescent Well-Care Visits, and Annual Dental Visit measures were conducted using two-tailed z-tests. For comparisons that were

statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) were reported.

The reported rate for Molina Healthcare for the Annual Dental Visit rate was 37.18%. This was consistent with the statewide rate for all MCHPs (41.84%, $z = -0.40$; 95% CI: 31.95%, 42.41%; n.s.). This rate is **higher** than the rates reported by the MCHP during of the last four review years: 30.45% in 2007, 30.53% in 2008, 33.38% in 2009, and 31.66% in 2010 (see Table 46 and Figure 45).

The HEDIS 2011 rate for Molina Healthcare for the Childhood Immunizations Status measure was 60.50%, which was consistent with the statewide rate for all MCHPs (57.47%; $z = 0.51$, 95% CI: 55.56%, 65.45%; n.s.). This rate has not been previously audited by the EQRO and therefore no data is available for trend analysis.

The HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure 7-day rate reported to the SMA and the State Public Health Agency (SPHA) by Molina Healthcare was 31.23%. This rate was **significantly lower** than the statewide rate for all MCHPs (45.61%; $z = -1.47$, 95% CI: 24.66%, 37.79%; $p < .05$). The 30-day rate reported was 45.40%, which was also **significantly lower** than the statewide rate (66.22%; $z = 0.25$, 95% CI: 38.83%, 51.97%; $p < .05$).

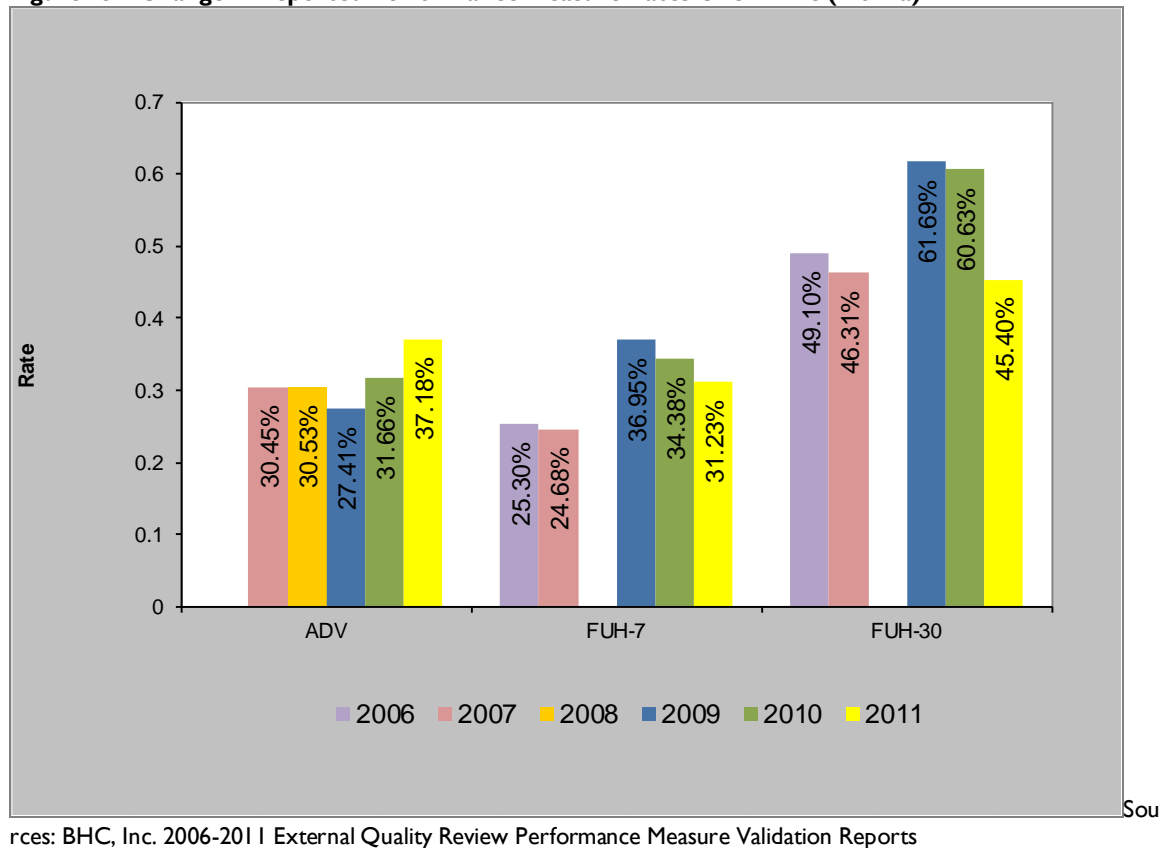
Both the 7-day and 30-day rates were **lower** than the rates reported for HEDIS 2010 (34.38% and 60.63% respectively) and appear to be continuing in a downward trend (see Table 46 and Figure 45).

Table 46 – Reported Performance Measures Rates Across Audit Years (Molina)

Measure	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	HEDIS 2009 Rate	HEDIS 2010 Rate	HEDIS 2011 Rate
Annual Dental Visit (ADV)	NA	30.45%	30.53%	33.38%	31.66%	37.18%
Childhood Immunizations Status – Combination 3 (CIS3)	NA	NA	NA	NA	NA	60.50%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	25.30%	24.68%	NA	36.95%	34.38%	31.23%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	49.10%	46.31%	NA	61.69%	60.63%	45.40%

Note: NA = the measure was not audited by the EQRO in that HEDIS reporting year

Figure 45 – Change in Reported Performance Measure Rates Over Time (Molina)



rces: BHC, Inc. 2006-2011 External Quality Review Performance Measure Validation Reports

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the main report for activities, ratings, and comments related to the CMS Protocol Attachments.

DATA INTEGRATION AND CONTROL

The information systems management policies and procedures for rate calculation were unable to be evaluated as required by the CMS Validating Performance Measures Protocol. Molina did not participate in the on-site visit process, and therefore the Data Integration and Control components were found Not Valid. For all three measures, Molina was found to meet none of

the criteria for producing complete and accurate data. The EQRO was unable to evaluate if any biases or errors were made in the manner in which they transferred data into the repository used for calculating the HEDIS 2011 measures.

DOCUMENTATION OF DATA AND PROCESSES

Data and processes used for the calculation of measures were unable to be adequately validated. Molina met none of the criteria applicable for each of the three measures. Molina states they utilize statistical testing and comparison of rates from year to year, but due to their refusal to participate in the on-site review, this was not confirmed on-site by the EQRO.

PROCESSES USED TO PRODUCE DENOMINATORS

Molina met none of the criteria for the processes employed to produce the denominators of all three performance measures. Due to Molina's refusal to participate in the on-site review, the EQRO was unable to assess that MCHP's information system in person, as required by the Validating Performance Measures Protocol. Assuming the system is valid, the selection of eligible members for the services being measured was reported. Age ranges, dates of enrollment, medical events, and continuous enrollment were programmed to include only those members who met HEDIS 2011 criteria.

A total of 45,230 eligible members were reported and validated for the Annual Dental Visit measure.

The Childhood Immunizations Status measure contained an eligible population of 3,565.

For the Follow-Up After Hospitalization for Mental Illness measure, a total of 522 eligible members were reported and validated by the EQRO.

PROCESSES USED TO PRODUCE NUMERATORS

All three measures included the appropriate administrative data ranges for the qualifying events (e.g., well-care visits, follow-up visits, or dental visits) as specified by the HEDIS 2011 criteria. A medical record review was conducted for the Childhood Immunizations Status measure, assuming the data is valid.

The number of Annual Dental Visit hits reported by the MCHP was 16,816; the EQRO was able to validate a total of 16,801. The rate reported by the MCHP was 37.18% and the rate validated by the EQRO was 37.15%; this resulted in a 0.03% estimated bias (overestimate) by Molina Healthcare.

For the Childhood Immunizations Status measure, Molina Healthcare used the Hybrid Method of calculation. Of the 30 medical records requested, 30 were received; all of these were able to be validated by the EQRO. As a result, the medical record review validated all 285 hybrid hits reported. The MCHP reported 1,407 administrative hits; of these, the EQRO was able to validate 1,393. Thus, the rate validated by the EQRO was 60.10% and the rate reported by the MCHP was 60.50%, representing an overestimation bias of 0.40% by the MCHP.

The Follow-Up After Hospitalization for Mental Illness measure 7-day rate contained a total of 163 administrative numerator events reported, of which all were able to be validated by the EQRO. Thus, the 7-day rates reported and validated were both 31.23%, showing no bias.

The 30-day rate showed reported administrative hits of 237; the EQRO was able to validate 235 hits. This yields a reported rate of 45.40% and a validated rate of 45.02%, indicating a bias (overestimate) of 0.38% in the rate.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Childhood Immunizations Status measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure.

SUBMISSION OF MEASURES TO THE STATE

Molina Healthcare submitted the Data Submission Tool (DST) for each of the three measures validated to the SPHA (the Missouri Department of Health and Senior Services; DHSS) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS

The following table shows the estimated bias and the direction of bias found by the EQRO. One measure showed no bias in the rate. The other measures were slightly overestimated, but these results still fell within the 95% confidence interval reported by the MCHP.

Table 47 - Estimate of Bias in Reporting of Molina HEDIS 2011 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	0.03%	Overestimate
Childhood Immunizations Status (Combination 3)	0.40%	Overestimate
Follow-Up After Hospitalization for Mental Illness (7-day)	No bias	N/A
Follow-Up After Hospitalization for Mental Illness (30-day)	0.38%	Overestimate

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet. Table 33 shows the final audit findings for each measure. All three measures (Follow-Up After Hospitalization for Mental Illness, Adolescent Well-Care Visits and Annual Dental Visit) were determined to be Invalid, as the MCHP did not participate in the on-site review process.

Table 48 - Final Audit Rating for Molina Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Not Valid
Childhood Immunizations Status	Not Valid
Follow-Up After Hospitalization for Mental Illness	Not Valid

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the MCHP. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No Managed Care Members qualified for the measure.

CONCLUSIONS

Three rates were validated for the MCHP. Two of these rates (ADV and CIS3) were consistent with and one rate (FUH) was **significantly lower** than the average for all MCHPs.

QUALITY OF CARE

Molina's calculated rate for the HEDIS 2011 Follow-Up After Hospitalization for Mental Illness measure was deemed Not Valid with specifications. The MCHP refused to participate in the on-site review, a required element of the EQR process. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered to Harmony members.

Both Molina's 7-day and 30-day rates for this measure were **significantly lower** than the average for all MCHPs. This indicates the members are receiving a **lower** quality of care than the average member for this measure. Both the 7-day and 30-day rates were also **lower** than both the National Medicaid and National Commercial averages; the MCHP's members are receiving a **lower** quality of care than the average Medicaid or Commercial member across the country.

Both rates have continued to drop **lower** than the rates reported for the same measure in 2009 and 2010, indicating the quality of care to members has **decreased**. The 30-day rate is the lowest that has been seen for this MCHP by the EQRO since 2007.

ACCESS TO CARE

The calculated rate by Molina for the HEDIS 2011 Annual Dental Visit rate was Not Valid with specifications; this measure is categorized as an Access/Availability of Care measure. Because only one visit is required for a positive “hit”, this measure effectively demonstrates the level of access to care that members are receiving. Because Molina did not participate in the on-site visit process, the measure could not be fully validated.

The rate reported by Molina for this measure was consistent with the average for all MCHPs. Molina’s members are receiving access to care that is consistent with the access available to the average Managed Care member. This rate was **higher** than the rates previously reported by the MCHP during the 2007, 2008, 2009, and 2010 EQR audits. However, the rate was **lower** than the National Medicaid average rate, indicating the MCHP’s members are receiving **lower** access to care than the average Medicaid member across the country.

TIMELINESS OF CARE

The MCHP’s calculation of the HEDIS 2011 Childhood Immunizations Status measure was Not Valid with specifications. This measure is categorized as an Effectiveness of Care measure and aims to measure the timeliness of the care received.

Molina’s reported rate for this measure was consistent with the average for all MCHPs. Therefore, Molina’s members are receiving a similar timeliness of care for this measure as the average MCHP member. This rate was not previously audited by the EQRO and therefore no comparison trend data is available. The rate was below both the National Medicaid and National Commercial averages; the MCHP’s members are receiving **less timely** care for this measure than the average Medicaid or Commercial member across the nation.

RECOMMENDATIONS

1. The MCHP must complete all required elements of the EQR review in order to receive ratings. The EQR is greatly disappointed in Molina's performance.
2. Continue to utilize statistical comparisons of rates from one year to another to assist in analyzing rate trends.
3. Continue the use of medical record review (when allowed by HEDIS specifications) as a way to continue to improve reported rates.
4. The MCHP's rates for both timeframes of the Follow-Up After Hospitalization for Mental Illness measure were once again **lower** than the previously audited rates. The MCHP should carefully analyze this **decrease** and employ interventions that might serve to reverse this substantial downward trend.
5. Work to **increase** rates for all measures; although most measures were consistent with the average for all MCHPs, all rates were below the National Medicaid averages.

11.3 MCHP Compliance with Managed Care Regulations

METHODS

Molina Healthcare of Missouri (Molina) was subject to a follow up compliance audit during this on-site review. The content of this 2011 calendar year audit will include all components of the Quality Standards as defined in 42 CFR 438. Evaluation of these components included review of:

- Defined organizational structure with corresponding committee minutes
- Policies and Procedures
- Organizational protocols
- Print materials available to members and providers
- Report results
- Staff interviews

The Team utilized an administrative review tool which was developed based on the CMS Protocol Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient MCHPs (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Regulations (Compliance Protocol). The evaluation included review of MCCI's compliance with Access Standards, Structure and Operations Standards, and Measurement and Improvement Standards. Utilizing these tools, Molina will be evaluated on the timeliness, access, and quality of care provided. This report will then incorporate a discussion of the MCHP's strengths and weaknesses with recommendations for improvement to enhance overall performance and compliance with standards.

The EQRO rating scale remains as it was during the last evaluation period.

M = Met

Documentation supports that all components were implemented, reviewed, revised, and/or further developed.

PM = Partially Met

Documentation supports some but not all components were present.

N = Not Met

No documentation found to substantiate this component.

N/A = Not Applicable.

Component is not applicable to the focus of the evaluation. N/A scores will be adjusted for the scoring denominators and numerators.

A summary for compliance for all evaluated Quality Standards is included in Table 49.

Table 49 - Comparison of Molina Compliance Ratings for Compliance Review Years (2009, 2010, 2011)

Measure	2009	2010	2011
<i>Enrollee Rights and Protections</i>	100%	100%	0%
<i>Access and Availability</i>	100%	76.5%	64.71%
<i>Structure and Operations</i>	100%	100%	0%
<i>Measurement and Improvement</i>	90.9%	100%	54.4%
<i>Grievance Systems</i>	100%	88.9%	44.4%

Description of the Data:

The review of Quality Standards was completed using a Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations.

FINDINGS

Enrollee Rights and Protections

Enrollee Rights and Protections address 13 standards. For the 2011 review, Molina was rated by the review team to have met 0 standards. This is an overall rating of 0.0% compliance, which is significantly lower than the 100% ratings received in 2009 and 2010. The MCHP received “Partially Met” for all standards in this category, as the EQRO was unable to verify that the practice at the MCHP met the policies that were reviewed.

Molina HealthCare of Missouri continued its efforts to track and monitor all policy required to be submitted to and reviewed by the SMA. This included policy and procedures for initial and annual approval, as well as marketing materials. Although Molina refused to participate in the on-site review, they supplied the EQRO with a copy of their Annual Marketing Materials and the Annual Marketing Plan.

The Member Handbook was approved by the SMA and was recorded in a format to be shared with members who are visually impaired or have other challenges with written material. Certified interpreters for deaf or non-English speaking members are provided as needed.

Access Standards

Access and Availability addresses 17 standards. For the 2011 review, Molina was rated by the review team to have met 11 standards. This is an overall rating of 64.71% compliance, which is significantly lower than the ratings of 76.5% and 100% received in 2010 and 2009 respectively.

Although Molina provided the EQRO with copies of its policies and procedures, the MCHP's refusal to participate in the on-site review leaves many questions unanswered. As with all other MCHP's, during on-site reviews the EQR team conducts interviews with Case Management and Administrative Staff. These interviews are designed to allow the EQR staff the opportunity to obtain answers to questions regarding the actual day-to-day practice of a MCHP.

In prior year's reviews, the EQR has discussed their specialty provider network with Molina staff, the EQRO was not able to assess Molina's progress in that area due to the lack of interview participation.

Additionally, the lack of opportunity to speak to Case Management staff requires the EQR team to evaluate the MCHP only on the documentation as presented. As such, evidence of assessments, treatment planning and follow up with members in case management was not found in many of the case files reviewed.

The rating regarding Compliance with Access Standards regulations is (64.71%). Molina submitted required policy and procedures to the SMA for their approval. However, Molina's refusal to participate in the on-site review did not allow the EQRO to inquire about missing assessments and treatment planning. Unlike prior reviews, the EQRO could not observe the commitment to good case management practice that has been observed in the past.

Structures and Operation Standards

The area of Structures and Operations addresses 10 standards. For the 2011 review, Molina was rated by the review team to have met zero standards. This is an overall rating of 0.0% compliance, which is **significantly lower** than the ratings received in 2009 and 2010 (100%). The ratings for compliance with Structure and Operation Standards (0.0%) reflected the MCHP's refusal to participate in the on-site review by the EQRO. The MCHP submitted all

required policy for approval however, the EQRO was not able to observe any practice to substantiate the policy during an on-site review.

The MCHP mentioned issues with subcontractors in their annual report that were unable to be discussed due to the MCHP's refusal to participate in the on-site review.

Measurement and Improvement

Measurement and Improvement addresses 12 standards. For the 2011 review, HCUSA was rated by the review team to have met 6 standards; two standards were found partially met; three standards were not met; and one standard was found to be Not Applicable. This is an overall rating of 54.54% compliance, which is **significantly lower** with the 100% ratings received in 2009 and 2010.

Although Molina HealthCare of Missouri provided the EQR with policy documentation, the EQR was unable to validate that the MCHP's policy was being carried out in practice. Verifying that the practice of a MCHP is consistent with approved policy is a requirement of the EQR. The EQRO was unable to verify the practice of the MCHP and therefore, Molina cannot receive full credit in the ratings for this area.

Molina HealthCare of Missouri submitted two Performance Improvement Projects (PIPs) for validation. The MCHP did provide their current Quality Initiative plan, which clearly indicated their commitment to this process. The structure of both PIPs followed the federal protocol and showed a great deal of potential. However, no clarification or additional information could be obtained due to the MCHP's refusal to participate in the on-site review.

The MCHP submitted all required information to complete the Validation of Performance Measures for all three measures, as requested. However, the MCHP's Information Systems could not be observed during an on-site review. The specific outcomes of the Performance Measure are discussed in the appropriate section of this report.

The rating for Measurement and Improvement (54.4%), was a significant decrease over the 2009

and 2010 review years' ratings of 90.9% and 100% respectively. This rating would have greatly improved had the EQRO been allowed to observe the MCHP during the onsite review. These policies and procedures are in place, but no practice could be verified.

Grievance Systems

Grievance Systems addresses 18 standards. For the 2011 review, Molina Care was rated by the review team to have met 8 standards. This is an overall rating of 44.44% compliance, which is **significantly lower** than the rating received in 2010 (88.9%) and the rating received in 2009 (100%).

Review of Grievance and Appeals Files

Unlike all other MCHP's, the EQRO was not able to review grievance and appeals files while on-site at Molina. Molina did supply the EQRO Project Director, Amy McCurry Schwartz, with copies of 29 of the requested 50 files on the date the on-site reading review was scheduled, June 25, 2012. These were supplied on CD and were reviewed by the Project Director. Of the remaining 21 files, 20 files were supplied via mail on CD to the EQR after the completion of all MCHP site visits. At the time of that communication, Molina also stated that they did not have one of the files. Because these files were not supplied during the on-site visit or during the period of on-site reviews, they were not valid.

Table 50 – Compliance File Review, Molina

MCHP	# of records reviewed	# with issue	% with issues	% Correct
Molina	50	21	42%	58%

Although no content issues were found in the 29 files that the EQR Project Director reviewed, these files will all receive a rating of "Partially Met" as they were not supplied during the on-site review as required by the EQRO communication to the MCHP, the MHD contract, and the Federal Regulations governing the EQR process.

The remaining files will receive a rating of "Not Met" as they were not presented to the EQRO in a timely manner.



State Inquiry Log review

The EQRO also reviewed the MCHP's response to any "inquiries" received by the SMA during the fourth quarter of Calendar year 2011 that pertained to a Molina member. Molina was requested to supply information regarding 20 inquiries made by the SMA during the 4Q11 timeframe. Molina did not provide any information regarding these inquiries. Because of their refusal to participate in the on-site review, the EQRO was unable to inquire about the MCHP's procedure for dealing with "State Inquiries".

Ratings for compliance with the Grievance Systems regulations (44.4%) indicate that the MCHP completed all of the requirements regarding policy, but this information was unable to be verified by practice.

CONCLUSIONS

Molina HealthCare of Missouri's refusal to participate in the onsite review greatly hampered their performance in the area of Compliance. The EQRO was not afforded the opportunity to validate any of the MCHP's practice during the onsite review. Additionally, the MCHP could not provide the requested Grievance and Appeals files on time, or at all. Therefore, the EQO has no choice but to find the MCHP deficient in all areas of compliance.

The EQRO continued to observe specific issues of partial compliance during this year's review, including:

- Missing treatment plans and assessments from Case Management files.
- Missing or incorrect information included in responses to Grievances and/or Appeals.

QUALITY OF CARE

During the 2009 on-site review Molina HealthCare of Missouri exhibited an improvement in the development of policies and procedures, and an upgrade in their organization's performance. However, during the 2010 review, the commitment to these goals was evident, but many of the promised progress was not clearly seen – the EQRO was not afforded the opportunity to observe the MCHP practice during an onsite review for 2011 and as such found the MCHP noncompliant.

ACCESS TO CARE

Molina HealthCare of Missouri did make a number of changes during the past few years to improve access to care for members. They were able to contract with a number of hospitals and physician groups that were previously not in their network. Their provider panel has expanded in the availability of primary care physicians and specialists. The MCHP instituted a method of contacting primary care physicians for members when members experience problems obtaining appointments.

However, the EQRO did not receive documentation of all the quality services described by MCHP staff. By not providing complete case management files, the EQRO could not validate that case management was being delivered when appropriate or to the degree required by the Managed Care contract.

TIMELINESS OF CARE

An attention to the issue of timeliness of care was also evident at the MCHP. They have improved **significantly** in the area of timely and complete policy submission. However, the EQRO was unable to validate that this policy is in practice at the MCHP during the onsite review.

RECOMMENDATIONS

1. Maintain improvements in the area of development and submission of policy and procedures for SMA approval. This is an important factor in establishing continued confidence in the MCHP's operations.
2. Be sure to supply all available information when requested by an auditing agency, if it is not in the file, it cannot be counted as meeting the requirements.
3. Monitor the areas of Grievances and Appeals for compliance with contract timelines and letter content.
4. The MCHP must participate in all required elements of an audit to receive full review, lack of participation results in much lower rates.